



MASSACHUSETTS

Blue Cross Blue Shield of Massachusetts is an Independent Licensee of the Blue Cross and Blue Shield Association.

# Certified Registered Nurse Anesthetist (CRNA) Contracting Application

Questions? Read our [Contracting Q & As](#).

Complete this form online. Leaving blanks will delay processing.

Send completed form to [BlueCrossContractOps@bcbsma.com](mailto:BlueCrossContractOps@bcbsma.com) or fax 617-246-5053.

If emailing, please include practitioner's Last Name, First Name in the Subject.

**Do not complete this application if your NPI type 1 will not appear on claims.**

Blue Cross\* will evaluate this application according to your ability to meet pre-established credentialing criteria and network need, as determined solely by Blue Cross.

We reserve the unqualified right to reject any and all applications, subject to the terms of this application and applicable law.

By accepting this application for evaluation, we agree that any patient-specific or identifying information, any non-publicly available information that you designate as confidential set forth in this application, and any non-publicly available information that is obtained in the application process will remain confidential unless its release is required or permitted by law, regulation, or valid court order.

**Please do not apply unless you meet the global and provider type credentialing requirements.** The requirements can be viewed at [bluecrossma.com/provider](http://bluecrossma.com/provider) in [Office Resources](#)>[Enrollment](#)>[Credentialing & Recredentialing](#)>[Credentialing](#).

Each practitioner must complete the online application through the Council for Affordable Quality Healthcare (CAQH) website at <https://proview.caqh.org>.

If...	Then...
You're already a CAQH provider	<ul style="list-style-type: none"> <li>Update all information (including expired documents).</li> <li>Choose the option to authorize all healthcare organizations. This will allow us to access your information.</li> </ul>
You're not a CAQH provider	<ul style="list-style-type: none"> <li>Log onto the CAQH website and self-register.</li> <li>Once registered, thoroughly complete your <i>Integrated Massachusetts Application</i> and submit all required documents.</li> </ul>
You're not sure of your status	Call CAQH at 1-888-599-1771.

### Please check one:

#### Q I am joining a group practice

- I am new to Blue Cross and joining a J U R X S practice that submits claims on a CMS-1500 or 83

#### Q I am contracting as a solo provider

- I bill under a Social Security Number or a Federal Tax Identification Number (EIN) as a sole proprietor, AND
- I do not currently reimburse any practitioners for services.

### Ready to send your application? Be sure to attach:

- A copy of your current NBCRNA certificate
- A copy of your current Advanced Cardiac Life Support certificate.

### Each new group or solo practice must also attach:

- A completed Practice Application (beginning on page 6) - submit only once per practice
- An IRS Form W-9 that is signed, dated, and completed with the name and Tax ID Number (EIN) to which payments will be made. We cannot process your request without a W-9. A form is attached.

**Practitioner information**

First name	
Last name	
National Provider Identifier (NPI Type 1)	
Social security number	
Date of birth	
Massachusetts license number	

**Office location**

Employment or start date at this practice (month/day/year)	
Practice name (legal name)	
DBA (if reported to the IRS)	
Practice's tax ID number	
Practice's NPI (Type 2 if group)	
Address	
City, state, ZIP	
Email	
Phone	
Fax	

**Billing address** – Please let us know us your remittance address.

Same as main practice location     Other (please enter below)

Billing name	
Address	
City, state, ZIP	
Email	
Phone	
Fax	

**Contract recipient** – We send all contractual agreements by secure email from *Blue Cross* <adobesign@adobesign.com>. Add this address as a trusted sender, and check your spam or junk mail folders to make sure you are receiving our email.

If we approve this application to join a Blue Cross group contract, we must email your contract Attachment *A directly to you (the practitioner)* for signature. You are required to personally sign to be legally bound to the practice's Agreement. Be sure to use an active email you check regularly.

Practitioner's email (required) \_\_\_\_\_

If you want someone to be copied when we email the practitioner, please provide their email  
\_\_\_\_\_

**Welcome letter recipient** – Before billing for services you provide to our members, you must register your practice with Payscale/EFT. Your welcome letter will include information about how to register.

Let us know where to email your welcome letter (required) \_\_\_\_\_

**Contact person** – Let us know the person to contact in case we have questions about this application. *Please note:* If we are unable to process your request due to missing information, we will notify this person via fax or email.

Name and business title	
Company name	
Email (required)	
Phone	
Fax	

**Professional information**

- Certification by the National Board of Certification and Recertification for Nurse Anesthetists (NBCRNA) is a Blue Cross credentialing requirement.
- Certification in Advanced Cardiac Life Support is a Blue Cross credentialing requirement.

Attach a copy of each current certificate clearly showing the expiration date, or we will not be able to process this application.

**Collaborative arrangement**

I comply with all requirements of the Mass. Board of Registration in Nursing as an Advanced Practice Nurse with **more than two years** of experience. (No need to submit collaborating physician information)

I comply with all requirements of the Mass. Board of Registration in Nursing as an Advanced Practice Nurse with **less than two years** of experience. My collaborating physician or peer information follows:

**Name of physician or CRNA (required)**      **Specialty**      **NPI (Type 1)**      **Hospital affiliation**

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### Covering arrangements

Blue Cross agreements require that providers establish arrangements to render care as needed when they are unavailable.

I attest that I have covering arrangements in place to ensure my patients have access to care when I am unavailable, in keeping with industry standards for my profession.

### Blue Cross Product participation

If you are joining a group practice, we will enroll you in the same Products as the group. If you are a solo provider, make your Product selection in the Practice Application that follows.

### Signature waiver

**Please check one box. This waiver is legally binding.**

I request a waiver of Blue Cross's requirement that all participating providers personally sign Blue Cross claim forms. This waiver will allow Blue Cross to accept claim forms submitted on my behalf that bear a facsimile signature or the printed words "signature waived" in lieu of my personal signature on the claim form.

By requesting this waiver I acknowledge and undertake full personal responsibility for all claims submitted to Blue Cross on my behalf pursuant to this waiver as if I had personally signed each claim form.

I understand that claims will be submitted to Blue Cross only for services rendered by me to patients with whom I have an expressed or implied contract to render services for a fee and in accordance with the provisions of my Blue Cross provider agreement.

I decline a signature waiver and agree to personally sign every claim submission.

## Release and representations by the applicant

Please read the following statements. You must sign and date this section before sending your application.

I understand that Blue Cross will re/credential participating providers pursuant to various requirements, including, but not limited to, credentialing requirements, contractual obligations, and/or regulatory requirements. My signature below will serve as a release and waiver to allow Blue Cross to access relevant information for purposes of credentialing and other quality concerns.

I release from any liability all representatives of Blue Cross for any acts performed in good faith in connection with the evaluation of this application.

I hereby affirm and represent that all statements, answers, and information in this application are true and complete to the best of my knowledge and belief.

I understand and agree that:

- Blue Cross's receipt of this application does not constitute approval or acceptance for network participation.
- I cannot provide covered services and be reimbursed as a participating provider until Blue Cross notifies me that my contract is in effect, at which time this application will become part of my contract.
- If Blue Cross accepts me for participation, information provided on this application may be made available to members, prospective members, employers, brokers, other providers, and government regulators.
- I must immediately send a *Contract Update Form* to Blue Cross when there are changes to any information in this application.
- Any misrepresentation or omission will be sufficient cause for immediate, unilateral termination by Blue Cross of any Blue Cross provider agreement.
- This release will be in effect upon the submission of this application and will remain in effect through the term of any ensuing provider contract.

Accepted and agreed to by the applicant:

Signature (required) \_\_\_\_\_  
Print name \_\_\_\_\_  
Date of signature \_\_\_\_\_

Send your completed, signed application and copies of current certificates as shown on page 1.

Keep a copy for your files.

If we approve this contracting application, we will send an Attachment A for your signature.

Thank you for your interest in caring for our members.



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# Certified Registered Nurse Anesthetists Practice Application

Submit this section only once per practice if you are opening a new practice or changing your practice's tax ID number

If you want a new contract with Blue Cross and your practice...	Then...
<ul style="list-style-type: none"> <li>• Bills for practitioners' services on a CMS-1500 or 837P using an Employer tax ID, and</li> <li>• Has not signed a Blue Cross group contract for your provider type, and</li> <li>• Has not already completed a CRNA Practice Application for the tax ID number entered below</li> </ul>	<ul style="list-style-type: none"> <li>• Complete this entire Practice Application.</li> <li>• Please send a form for each practice member. We cannot process your request for a contract without details on each practitioner.</li> </ul>
<ul style="list-style-type: none"> <li>• Is a solo practice</li> </ul>	<ul style="list-style-type: none"> <li>• Complete this Practice Application except for the sections called Contract recipient, Practice owners, and Practice members.</li> </ul>

### Main practice location

Same address entered on page 2 for the practitioner     Other (please enter below)

Practice name (legal name)	
DBA (as it appears on the W-9)	
Practice's tax ID number (same number as on the W-9)	
Practice's NPI that you bill under (Type 2 if group practice)	
Practice address	
City, state, ZIP	
Email	
Phone to schedule appointments	
Fax	

**Contract recipient** – We sent all contractual agreements by secure email from *Blue Cross* <adobesign@adobesign.com>. Add this address as a trusted sender, and check your spam or junk mail folders to make sure you are receiving our email.

If we approve this application for a new contract, we must email your agreement **directly to someone authorized to sign** contracts on behalf of your practice, such as *owner, partner, president*.

Authorized signer's name	Business title	Email (required)

If you want someone to be copied when we email the authorized signer, please provide their email

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**Contact person** – Let us know the person to contact in case we have questions about this application.  
*Please note:* If we are unable to process your request due to missing information, we will notify this person via fax or email.

Name and business title	
Company name	
Email (required)	
Phone	
Fax	

**Practice owner(s)**

Name

1	
2	
3	

**Communications**

You must become a registered, active user of our secure website, [bluecrossma.com/provider](http://bluecrossma.com/provider), to access the latest fee schedules, forms, policies, contractual notices, and other communications. You (or your practice) will need to keep your e-mail address current, so we can send you important notices.

If we contract with you, your welcome letter will include instructions on how to register for our website.

**By checking this box, I affirm that:**

Our practice agrees to comply with this requirement

**Reimbursement**

We use e-payment as our standard method of payment for provider reimbursement, at no cost to our providers. E-payment is a secure online direct deposit into your bank account that occurs via electronic funds transfer (EFT). Enrolling in e-payment offers an additional benefit of online access to your payment advisories. You will need to register for and use Payspan (an electronic tool for EFT and online advisories) to get reimbursement for services rendered to Blue Cross members.

If we contract with you, your welcome letter will include instructions on how to register for Payspan/EFT.

Our practice agrees to comply with this requirement

**Welcome letters** – Your practice's welcome letter will include your Blue Cross Product participation and contract effective date.

Each CRNA in your group will receive a separate welcome letter showing their effective date; this is when they may begin treating our members.

Let us know where to email your practice's welcome letter

Email (required) \_\_\_\_\_

## Blue Cross Product participation

If your practice will render services at an ambulatory surgery center, you should apply for the same Blue Cross Products as the ASC participates in. Please list the ASC(s) below:

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*Please note:* All CRNAs in the group must participate in the same Products.

Check the Products you want to participate in:

All Products

HMO     PPA/PPO     Indemnity     Medicare Advantage HMO     Medicare Advantage PPO

For more information about the Products, look on [bluecrossma.com/provider](http://bluecrossma.com/provider) in [Patient Resources>Plans & Products>Product Overview](#).

## Practice members

How will new practice members be joined to your group contract?

By signature of each practitioner

Through binding authority

*(Consult your legal counsel to ensure your practice has full and complete authority to bind practitioners to the terms and conditions of your contract for all Blue Cross Products you have requested)*

Send a form for each CRNA joining your practice. We cannot process your request for a contract without additional details on each practice member.

If a practitioner is...	Then...
Already participating with Blue Cross	Send a <i>Contract Update Form</i> in order to join them to your group agreement. The form is on Provider Central at <a href="#">Forms&gt;Contract Updates</a> .
New to Blue Cross	Send a <i>Contracting Application</i> after they have updated their CAQH profile at <a href="https://proview.caqh.org">https://proview.caqh.org</a> . Download applications from Provider Central at <a href="#">Forms&gt;Contracting Applications</a> .



## Release and representations by the practice

Please read the following statements. You must sign and date this section before sending your application for a new contract.

By my signature below, I represent and warrant that I am duly authorized to complete this application on behalf of the applicant and group practice named above.

I release from any liability all representatives of Blue Cross for any acts performed in good faith in connection with the evaluation of this application.

I hereby affirm and represent that all statements, answers, and information in this application are true and complete to the best of my knowledge and belief.

I understand and agree that:

- Blue Cross's receipt of this application does not constitute approval or acceptance for network participation.
- My group practice cannot provide covered services and be reimbursed as a participating provider until Blue Cross notifies us that our contract is in effect, at which time this application will become part of our contract.
- If Blue Cross accepts my practice for participation, information provided on this application may be made available to members, prospective members, employers, brokers, other providers, and government regulators.
- My practice must immediately send a *Contract Update Form* to Blue Cross when there are changes to any information in this application.
- Any misrepresentation or omission will be sufficient cause for immediate, unilateral termination by Blue Cross of any Blue Cross provider agreement.
- This release will be in effect upon the submission of this application and will remain in effect through the term of any ensuing provider contract.

Accepted and agreed to on behalf of the practice by:

Representative's signature (required)

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Print name

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Business title

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Email

(required)

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Business name

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Date of signature

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Send your completed, signed application as shown on page 1. Keep a copy for your files.

Attach an IRS Form W-9 that is signed, dated, and completed with the name and tax ID number to which payments will be made. We cannot process your request without a W-9.

If we send you a contract, please remember that only the authorized signer may sign.

\* Blue Cross refers to Blue Cross and Blue Shield of Massachusetts, Inc., Blue Cross and Blue Shield of Massachusetts HMO Blue®, Inc., and/or Massachusetts Benefit Administrators LLC, based on Product participation.

