



MASSACHUSETTS

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

Contract Update Form for Physicians

Questions? Write ProviderApplicationStatus@bcbsma.com or call 1-800-316-2583.

Send completed form to NetworkManagement@bcbsma.com or fax 1-617-246-4227.

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

Use this form to notify Blue Cross* of a change to a contracted physician's practice status, etc. Keep a copy of this completed form for your files. If needed, you will receive a new contract for signature.

You cannot provide covered services and be reimbursed as a participating provider in any new practice or new Product until you are notified by Blue Cross that the new contract is in effect.

Check all that apply:

- Leaving your current practice and joining a new practice that will bill for your services on a CMS-1500 or 837P
- Staying with your current practice and joining a new practice
- Opening a practice
- Changing your practice's Tax ID number
- Changing your primary care (PCP) status
- Changing your practice availability
- Updating your specialty or board certification status
- Changing a hospital affiliation
- Want to add a Product to your Agreement

And complete these sections:

- 1, 2, 3, 4, 7, 9, 10, 12, 13
- 1, 4, 5, 7, 9, 10, 12, 13
- 1, 2, 4, 5, 7, 9, 10, 11, 12, 13, Group Practice Attachment
- 1, 5, 11, 12, 13, Group Practice Attachment
- 1, 5, 6, 12
- 1, 5, 7, 12
- 1, 5, 8, 12
- 1, 5, 10, 12
- 1, 2, 5, 9, 12, 13

Section 1. Individual practitioner information

Name _____

License number _____

National Provider Identifier (NPI Type 1) _____

Email (required) _____

Section 2. Blue Cross Product participation

- To add a Product, please check **all** Products that you want to participate in.
- If you are joining a group practice, we will enroll you in the same Products as the group.
However, if your specialty is limited to pediatrics, you may choose whether to participate in Medicare Advantage.
- If you are remaining as an independently practicing physician only, please check **all** Products in which you wish to participate.

- HMO PPA/PPO Indemnity Medicare Advantage HMO Medicare Advantage PPO

* 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. ®Registered Mark of the Blue Cross Blue Shield Association.

Section 3. Leaving a practice

By leaving a practice, you will also be leaving the Product participation associated with that practice. You must indicate in section 2 the Products in which you now wish to participate.

If you are leaving your primary contracted group, they will need to submit a termination in order to remove their group contract from your profile.

If leaving all Blue Cross practices, please submit the *Standardized Provider Information Change Form* instead of this form.

Date leaving practice _____
Practice name _____
Practice's NPI (Type 2) _____
Practice location _____
City, state, ZIP _____
Phone () _____

At this practice you are enrolled as a (check one): PCP Specialist Both

Section 4. Joining or opening a new practice

If your group has a new Tax ID and Type 2 NPI, please also complete the Group Practice Attachment on page 5.

Please verify with physician and check one: This will be the physician's new Primary practice
 This will be a secondary practice affiliation

Solo providers: If this address is your home, please be aware that it will be shown in our directory as a "practice" address.

Employment or start date _____
Practice name _____
DBA (as reported to the IRS) _____
Practice's tax ID number _____
Practice's NPI (Type 2 if group) _____
Practice location* _____
City, state, ZIP _____
Phone to schedule appointments () _____ Fax () _____
Hospital affiliation (required) _____

At this practice you wish to be enrolled as a (check one): PCP Specialist Both

*Practice locations are where patients can make an appointment to see you. Each location must have a separate, designated space for providing care to patients, ensuring privacy during treatment.

Additional locations Check if you provide services at additional locations, and complete the last page of this form.

Billing address Same as above Other:

Billing name _____
Address _____
City, State, ZIP _____
Email _____
Phone (-) _____ Fax () _____

Billing for Diagnostic Imaging Services

If the practice intends to begin billing Blue Cross for diagnostic imaging services (professional and/or technical component), please download the appropriate privileging application from bluecrossma.com/provider. In Office Resources, click Privileging.

Even if a physician has technical component privileges at another practice, they must obtain privileges for a new practice by submitting an application. However, when a physician intends to continue billing for the same professional component services and **does not** intend to bill any technical component services at a new practice, they do not need to submit any privileging applications.

Section 5. Existing practice

This is the physician's: Primary practice Secondary practice (please verify with the physician and check one)

Practice name _____

Practice's tax ID number _____

Practice's NPI (Type 2 if group) _____

Practice location* _____

City, State, ZIP _____

Email _____

Phone to schedule appointments () _____ Fax () _____

At this practice you are enrolled as: PCP Specialist Both (please verify with the physician and check one)

Hospital affiliation (required) _____

*Practice locations are where patients can make an appointment to see you. Each location must have a separate, designated space for providing care to patients, ensuring privacy during treatment.

Additional locations Check if you provide services at additional locations, and complete the last page of this form.

Section 6. Changing primary care enrollment status

Please indicate the type of change you are making:

- You are a specialist enrolling as a PCP at your primary practice and terminating your specialist status
- You are enrolling as both a PCP and specialist at your primary practice
- You are a PCP enrolling as a specialist at your primary practice and terminating your PCP status
- You are a PCP enrolling as a specialist at a secondary practice and remaining a PCP at your primary practice

Section 7. Changing practitioner availability status

Check all locations where you wish to make changes.

At your Existing practice shown in section 5 New practice shown in section 4, you will be:

- Accepting new patients
- Not accepting new patients

Will you offer telehealth? Yes No

I understand that to serve Blue Cross Blue Shield members, I must be contracted with the local plan where my practice is physically located. (required)

Comments: _____

Section 8. Updating specialty or board certification status

This information will be shown on your Find a Doctor profile in our provider directory.

Primary specialty _____

Board certified? Yes No

Please list all additional specialties

Board certified? Yes No

Board certified? Yes No

Board certified? Yes No

Section 9. Covering arrangements

This section is required for Primary Care Physicians joining a practice

Primary Care Physicians: You must provide 24-hour coverage. Do you have 24-hour coverage? Yes No

Please list the individuals and/or groups that provide coverage for you. Covering providers must be contracted with Blue Cross.

Name of primary care provider or group practice

NPI

Specialty Care Physicians: Blue Cross agreements require that providers maintain 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.

Section 10. Hospital affiliation and admitting privileges

You (the physician) are: changing your primary hospital affiliation adding a secondary hospital affiliation

Name of hospital _____

Initial date of appointment (MM/DD/YY) _____

Does your current professional staff status include admitting privileges? Yes No

If you do not have admitting privileges at the above hospital, please indicate who arranges for your inpatient admissions.

This arrangement will continue until you notify Blue Cross of a change.

Name of primary care physician, practice, or hospitalist program

List any secondary hospital affiliations that you want to appear with your name in our provider directory

Section 11. New IRS Form W-9

A new W-9 is required to verify new billing information. If you are joining a contracted group, you do not need to attach a W-9.

The attached IRS Form W-9 has been completed with the name and Tax ID number to which payments will be directed.

Section 12. Representations

By checking this box, you hereby affirm and represent that all statements, answers, and information included in this Contract Update Form are true and complete to the best of your knowledge and belief, and that you are duly authorized to provide information on behalf of the physician named in section 1.

Name of person completing form _____

Business title _____

Company name _____

Email _____

Phone () _____ Fax () _____

Date _____

Section 13. Contract recipient

If we need to send you a new contract Attachment A, we must email it **directly to you (the practitioner)** for signature. You are required to personally sign a new Attachment A to be legally bound to the practice's Agreement. Be sure to use an active email you check regularly.

Practitioner's email (required) _____

You will receive a welcome letter showing the date you may begin treating our members at the new practice.

Email for welcome letter (required) _____

Additional Practice Locations for Appointments

Practitioner		NPI (Type 1)	
Practice name		Practice NPI (Type 2)	

The above is your: Existing practice A practice you are joining or opening

Only locations where patients can make appointments to see you will be displayed in our provider directory, *Find a Doctor & Estimate Costs*.

We require a complete list of these locations, but please note that only five addresses (*including the practice address you entered on page 2 or 3 of this form*) will be displayed in the directory.

For each address below, please check one box:

- **Appointments** – You see patients at this address, and they can make an appointment to see you here
- **Visits** – You see patients at this address but not by appointment (*listing these is not required*)
- **Covering** – You cover or fill-in at this address (*listing these is not required*)
- **Tests** – You read tests or perform imaging at this address (*listing these is not required*)

For the practice and NPI above, please list all additional locations *where patients can make appointments to see you*. How many copies of this page have you attached to the Update Form?

Location name			
Address			
City, state, ZIP			
Phone to schedule appointments		Fax	

Check one (required) Appointments* Visits* Covering Tests

Location name			
Address			
City, state, ZIP			
Phone to schedule appointments		Fax	

Check one (required) Appointments* Visits* Covering Tests

Location name			
Address			
City, state, ZIP			
Phone to schedule appointments		Fax	

Check one (required) Appointments* Visits* Covering Tests

Location name			
Address			
City, state, ZIP			
Phone to schedule appointments		Fax	

Check one (required) Appointments* Visits* Covering Tests

Location name			
Address			
City, state, ZIP			
Phone to schedule appointments		Fax	

Check one (required) Appointments* Visits* Covering Tests

*Each location must have a separate, designated space for providing care to patients, ensuring privacy during treatment.

Please notify us if the above information changes.

Request for Taxpayer Identification Number and Certification

**Give Form to the
 requester. Do not
 send to the IRS.**

▶ Go to www.irs.gov/FormW9 for instructions and the latest information.

Print or type.	See Specific Instructions on page 3.	<p>1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.</p> <hr/> <p>2 Business name/disregarded entity name, if different from above</p> <hr/> <p>3 Check appropriate box for federal tax classification of the person whose name is entered on line 1. Check only one of the following seven boxes.</p> <p><input type="checkbox"/> Individual/sole proprietor or single-member LLC <input type="checkbox"/> C Corporation <input type="checkbox"/> S Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Trust/estate</p> <p><input type="checkbox"/> Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=Partnership) ▶ _____</p> <p>Note: Check the appropriate box in the line above for the tax classification of the single-member owner. Do not check LLC if the LLC is classified as a single-member LLC that is disregarded from the owner unless the owner of the LLC is another LLC that is not disregarded from the owner for U.S. federal tax purposes. Otherwise, a single-member LLC that is disregarded from the owner should check the appropriate box for the tax classification of its owner.</p> <p><input type="checkbox"/> Other (see instructions) ▶ _____</p>	<p>4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):</p> <p>Exempt payee code (if any) _____</p> <p>Exemption from FATCA reporting code (if any) _____</p> <p style="font-size: small;">(Applies to accounts maintained outside the U.S.)</p>
		<p>5 Address (number, street, and apt. or suite no.) See instructions.</p> <hr/> <p>6 City, state, and ZIP code</p> <hr/> <p>7 List account number(s) here (optional)</p>	<p>Requester's name and address (optional)</p> <hr/>

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the instructions for Part I, later. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN*, later.

Note: If the account is in more than one name, see the instructions for line 1. Also see *What Name and Number To Give the Requester* for guidelines on whose number to enter.

Social security number								
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Employer identification number								
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Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions for Part II, later.

Sign Here	Signature of U.S. person ▶	Date ▶
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General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. For the latest information about developments related to Form W-9 and its instructions, such as legislation enacted after they were published, go to www.irs.gov/FormW9.

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following.

- Form 1099-INT (interest earned or paid)

- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)
- Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
- Form 1099-C (canceled debt)
- Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See What is backup withholding, later.