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

Contract Update Form for Physicians

Questions? Email *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. as listed below. Please retain a copy of this completed form for your files. If needed, a new contract will be mailed for you to complete and return.

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:		**Please complete sections:**
q	You are leaving your current practice and joining a new practice that will bill for your services on a CMS-1500 or 837P	1, 2, 3, 4, 7, 9, 10, 12, 13
q	You are staying with your current practice and joining a new practice	1, 4, 5, 7, 9, 10, 12, 13
q	You are opening a practice	1, 2, 4, 5, 7, 9, 10, 11, 12, 13, Group Practice Attachment
q	You are changing your practice's Tax ID number	1, 5, 11, 12, 13, Group Practice Attachment
q	You are changing your primary care (PCP) status	1, 5, 6, 12
q	You are changing your practice availability	1, 5, 7, 12
q	You are updating your specialty or board certification status	1, 5, 8, 12
q	You are changing a hospital affiliation	1, 5, 10, 12
q	You wish to add a Product to your Agreement	1, 2, 5, 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, you must be enrolled in the same Products that the group participates in. However, if your specialty is limited to pediatrics, enrollment in Medicare Advantage is optional.

§ If you are remaining as an independently practicing physician only, please check **all** Products in which you wish to participate.

q HMO q PPA/PPO q Indemnity q Medicare Advantage HMO q 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 NPI (Type 2): _____

Main practice location: _____

City, State, Zip code: _____

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

Employment or start date: _____

Practice name: _____

DBA (as reported to the IRS): _____

Practice Tax ID number: _____

Practice NPI (Type 2): _____

Main practice location: _____

City, State, Zip code: _____

Phone to schedule appointments: ( ) Fax: ( ) _____

Hospital affiliation (required): _____

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

Can patients make an appointment with you at this location using this phone number? q Yes q No

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

Billing address q Same as above q Other:

Billing name: _____

Address: _____

City, State, Zip code: _____

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

Each location must have a separate, designated space in which to provide care to patients to ensure their privacy during treatment.

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

Practice name: _____

Practice Tax ID number: _____

Practice NPI (Type 2): _____

Main practice location: _____

City, State, Zip code: _____

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): _____

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

Section 6. Changing Primary Care 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 Arrangement

Arranging for 24-hour coverage is a Blue Cross credentialing and contractual requirement. Please list the individuals and/or groups that provide coverage for you. Covering providers must be participating in the same Products that you requested in Section 2.

Physician or Group Practice Name	NPI

Section 10. Hospital Affiliation

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

Name of hospital (required): _____

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

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

Section 11. New 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: _____

Title: _____

Business name: _____

Email: _____

Phone: ( ) Fax: ( )

Date: _____

Section 13. Contract Recipient

Each practitioner is 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): _____

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Group Practice Attachment

Only complete this page if you are opening a new practice with a Type 2 NPI.

Practice Administration

Please list those who are authorized to sign contracts on behalf of the practice, such as Owner, Partner, President.

Name	Title

Practice owner(s)

Hospital Affiliation

Please identify the group's primary hospital affiliation:

Practice Members

- § Please list all physicians in the practice. Attach an additional sheet if needed.
- § Each physician who is **not currently participating with Blue Cross** must complete the HCAS Provider Enrollment Form.
- § Each physician who is **currently participating with Blue Cross** must complete a separate Contract Update Form for Physicians. Go to bluecrossma.com/provider. Under Forms, click Forms Library > Contract Update Forms.
- ▪ These clinicians must be enrolled in the same Products as the group. However, if their specialty is limited to pediatrics, they may choose whether to participate in Medicare Advantage.

Physician Name	MD Specialty	NPI (Type 1)	Participate in Medicare Adv? Y/N	PCP, Specialist, or both	Primary or Secondary

Additional Practice Locations

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

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

For the practice and NPI above, we require a complete list of locations where you will or do provide services.

How many copies of this page have you attached? ☐

Please note that only five locations (*including your primary practice location*) will be displayed in our provider directory, *Find a Doctor & Estimate Costs*. Only locations where patients can make appointments to see you will be displayed.

For each address, 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
- **Covering** – You cover or fill-in at this address
- **Tests** – You read tests or perform imaging at this address

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.

Form **W-9**
(Rev. October 2018)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

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

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

Print or type. See **Specific Instructions** on page 3.

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.

2 Business name/disregarded entity name, if different from above

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.

☐ Individual/sole proprietor or single-member LLC ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=Partnership) ► _____

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.

☐ Other (see instructions) ►

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):

Exempt payee code (if any) _____

Exemption from FATCA reporting code (if any) _____

(Applies to accounts maintained outside the U.S.)

5 Address (number, street, and apt. or suite no.) See instructions.

Requester's name and address (optional)

6 City, state, and ZIP code

7 List account number(s) here (optional)

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

			–			–				

or

Employer identification number

		–							

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** ►

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.*