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Contract Update Form

for Behavioral Health Professionals

Fax completed form to 617-246-5053.
Questions? Please call 1-800-316-BLUE (2583).

Use this form to notify Blue Cross* of a change to a contracted practitioner'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:**
❑ You are leaving your current practice and joining a new practice that will bill for your services on a CMS-1500 or 837P	All sections except #6, 11, 12, 13 Complete the Behavioral Health Clinical Profile
❑ You are staying with your current practice and joining a new practice	All sections except #2, 4, 11, 12, 13 Complete the Behavioral Health Clinical Profile
❑ You are opening a practice	All sections except #4, 11, 12. Complete the Group Practice Attachment and Behavioral Health Clinical Profile
❑ You are changing your practice's Tax ID number	1, 6, 13, 14, 15, Group Practice Attachment
❑ You wish to add a network (Product) to your Agreement	1, 2, 3, 6, 14, 15. Nurses: also complete section #7
❑ You are changing your practice availability	1, 6, 10, 14
❑ You are a psychiatrist updating your specialty	1, 6, 11, 14, Behavioral Health Clinical Profile
❑ You are a nurse changing your collaborating physician	1, 6, 7, 8, 14
❑ You are a psychiatric nurse practitioner (PNP) changing your certification	1, 6, 12, 14, Behavioral Health Clinical Profile

Section 1. Individual Practitioner Information

Name: _____

Specialty: _____

License number: _____

National Provider Identifier (NPI Type 1): _____

Email: (required) _____

Section 2. Blue Cross Product Participation

- To add a network (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.
- If you are remaining as an independently practicing provider only, please check **all** Products that you want to participate in.

❑ HMO ❑ PPA/PPO ❑ Indemnity ❑ Medicare Advantage HMO* ❑ Medicare Advantage PPO*

*Medicare Advantage is not applicable to LADCs-I, LMFTs, or LMHCs and is optional for Child Psychiatrists.

* 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. (no longer required)

Section 4. Leaving a Practice

By leaving a practice, you will also be leaving the network (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): _____

Practice Address: _____

City, State, Zip code: _____

Phone: ( ) _____

Section 5. 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 (last page of this form).

Please verify with clinician and check one:
- ❑ This will be the clinician'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): _____

Practice Address: _____

City, State, Zip code: _____

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

Can patients contact the provider to make an appointment with them at this location? ❑ Yes ❑ No

Additional locations ❑ Check this box if you provide services at additional locations that bill using the same NPI as above. Attach a list of the additional locations to this form. Please be sure to indicate if patients are able to make an appointment with the provider at each location. Blue Cross will not display locations in our provider directory if patients are not able to make an appointment for that provider at the location listed.

Billing address ❑ Same as above ❑ Other:

Billing name: _____

Address: _____

City, State, Zip code: _____

Email: _____

Phone: ( ) _____ Fax: ( ) _____

Clinical Profile

If you are leaving a group and starting an independent practice, please complete the attached Clinical Profile so that your correct practice information appears in our provider directory.

Section 6. Existing Practice

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

Please verify with clinician and check one:
- ❑ This is the clinician's Primary practice
- ❑ This is a Secondary practice affiliation

Practice name: _____

DBA (as reported to the IRS): _____

Practice Tax ID number: _____

Practice NPI (Type 2): _____

Practice Address: _____

City, State, Zip code: _____

Email: _____

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

Can patients contact the provider to make an appointment with them at this location? ❑ Yes ❑ No

Additional locations ❑ Check this box if you provide services at additional locations that bill using the same NPI as above. Attach a list of the additional locations to this form. Please be sure to indicate if patients are able to make an appointment with the provider at each location. Blue Cross will not display locations in our provider directory if patients are not able to make an appointment for that provider at the location listed.

Section 7. Collaborating Arrangement

This section is required if you are a PNP or PCNS joining a practice or changing your collaborating physician.

Please indicate your collaborating ("supervising") physician(s). The physician must be either board-certified or board-prepared in psychiatry.

Psychiatrist's Name	**NPI**

Section 8. Practice Guidelines Statement

This section is required if you are a PNP or PCNS joining a practice or changing your collaborating physician.

❑ By checking this box, I attest that I have signed mutually agreed-upon, written practice guidelines with the psychiatrist(s) named above.

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 #2.

Clinician or Group Practice	**NPI**

Section 10. Changing Practitioner Availability Status

At your ❑ existing practice shown in section 6 ❑ new practice shown in section 5, you will be:

❑ Accepting new patients

❑ Accepting existing patients only

❑ Closed (not accepting new patients and not accepting existing patients) *You must notify us 90 days before you intend to close your practice. Our directory will show your practice as closed 90 days from our receipt of this form.*

Will you offer telehealth/telemedicine (i.e., video visits)? ❑ Yes ❑ No

Section 11. Updating Specialty or Board Certification Status *For psychiatrists*

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 12. (no longer required)

Section 13. 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 14. 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 practitioner named in section 1.

Name of person completing form: _____

Title: _____

Business name: _____

Email: _____

Phone: ( ) _____ Fax: ( ) _____

Date: _____

Section 15. Contract Recipient

To join a practice you must sign a new Attachment A.

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): _____

MASSACHUSETTS

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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 and Title	**Email** (required)

Practice owner(s)

Practice Members

- Please list all clinicians in the practice. Attach an additional sheet if needed.
- Each clinician who is **not currently participating with Blue Cross** must also complete a Blue Cross Contracting Application. You can download the application at bluecrossma.com/provider. In Office Resources, click Enrollment > Contracting Applications.
- Each clinician who is **currently participating with Blue Cross** must complete a Contract Update Form for Behavioral Health Professionals. Log onto bluecrossma.com/provider. In Office Resources, click Enrollment > Maintaining & Changing Status.
- If the group wishes to participate in Medicare Advantage, all clinician must have active Medicare participating PTANs within six (6) months. If a clinician's PTAN is pending, please note the date he/she applied for status change. A clinician who does not have a Medicare participating PTAN will **not** be enrolled in Medicare Advantage at this time. Please submit a new Contract Update Form when you receive the clinician's individual Medicare participating PTAN.
- LADCs-I, LMHCs, LMFTs, and Child Psychiatrists are exempt from participation in Medicare Advantage.

Clinician Name	**Licensure type**	**NPI (Type 1)**		**Primary or Secondary with this group**

MASSACHUSETTS

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Behavioral Health Clinical Profile

Information from this Clinical Profile will be made available to members to aid them in accessing appropriate care.

Provider's name: _____

Provider's NPI: _____

Client Information

Check the age ranges of the client populations to which you offer services:

- ❑ Older adults (65 and over)
- ❑ Older children (5 to 11)
- ❑ Adults (18 to 64)
- ❑ Younger children (0 to 4)
- ❑ Adolescents (12 to 17)

List any languages (including sign language) other than English that you speak fluently and in which you can provide treatment:

_____

Areas of Expertise

Check all that pertain to the types of treatments you provide:

- ❑ Behavioral therapy
- ❑ Couples therapy
- ❑ Cognitive behavioral therapy
- ❑ Dialectical behavioral therapy
- ❑ Family therapy
- ❑ Group therapy
- ❑ Individual therapy
- ❑ Neuropsychological testing
- ❑ Outpatient medical detox services
- ❑ Psychological testing
- ❑ Psychopharmacology

Please check all that pertain to the types of disorders you treat:

- ❑ Adjustment disorders
- ❑ Anxiety disorders
- ❑ Attention deficit disorders
- ❑ Autism spectrum disorders
- ❑ Chronic mental disorders
- ❑ Conduct disorders
- ❑ Depressive disorders
- ❑ Developmental disorders
- ❑ Eating disorders
- ❑ Obsessive compulsive disorders
- ❑ Organic mental disorders
- ❑ Personality disorders
- ❑ Sexual dysfunctions
- ❑ Substance use

Please check all that pertain to the types of subspecialties you treat:

- ❑ ACOA/Co-dependency
- ❑ Adoption
- ❑ AIDS/HIV
- ❑ Chronic medical illness
- ❑ Chronic pain
- ❑ Gambling addictions
- ❑ Gay/lesbian
- ❑ Grief counseling
- ❑ Health care professionals
- ❑ Hearing impaired
- ❑ Homebound patients
- ❑ Internet addictions
- ❑ Law enforcement professionals
- ❑ Military professionals/family
- ❑ New immigrants
- ❑ Nursing home patients
- ❑ PTSD
- ❑ Physical abuse
- ❑ Physical disabilities
- ❑ Sexual abuse
- ❑ Sexual addictions
- ❑ Trauma

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.*