BlueCross BlueShield of New Mexico

GROUP PROVIDER RECORD/CONTRACTING PACKET

The **Group Provider Record/Contracting Packet** should be completed by:

- A provider who has a practice with more than one professional provider
- A provider whose Federal Tax Identification Number has a corporate legal name
- A billing entity that is incorporated

The attached packet contains the forms required in order to assign a Blue Cross and Blue Shield of New Mexico (BCBSNM) internal Group Provider Record and/or join the network for your organization and the providers affiliated to your organization. Please fully complete all applicable information in its entirety and forward the completed packet to Network Services by fax *(preferred method)* or by mail. The fax number and mailing address are indicated below.
Please discard any older applications, as they are no longer valid.

Billing Information – The name that will appear on any reimbursement or Form 1099 will be that of the party to which payment is made. We will only make provider payments to the group or association that rendered the service(s) and supplied a TIN or EIN belonging to the named group or association.

If you checked the box on the form to participate in the BCBSNM Networks, you will receive a Medical Services Entity Agreement (MSEA).

Important – Please Note: Your assigned organization's BCBSNM internal Group Provider Record does NOT mean that your organization or your individual providers are participating providers. Until each of your affiliated providers are contracted and credentialed and have an effective date, their claims will be processed as out-of-network.

To become a BCBSNM participating provider, each individual provider affiliated to your organization will need to be contracted *(if applicable)* and credentialed with BCBSNM. Please check the appropriate box on the form below. Then go to **Step 2** for contracting information *(if applicable)* and **Step 3** for CAQH credentialing information.

We look forward to assisting you in the future.

Complete the forms on-screen, print them using your Internet browser's print function, sign them, and return to:
Fax: 1-866-290-7718
Phone: (505) 837-8800
or 1-800-567-8540

Blue Cross and Blue Shield of New Mexico
Attn: Network Services Department
P.O. Box 27630
Albuquerque, NM 87125-7630

BlueCross BlueShield of New Mexico

Group Information

Applying for:	**Applying as:**	**Requested Networks:**
☐ Provider Record only ☐ Provider Record and Participation in the BCBSNM Network ☐ Participation in an additional BCBSNM Network only	☐ Primary Care Physician ☐ Specialist Physician ☐ Other Health Care Professional Providers	☐ Commercial (HMO, PPO, POS, PAR, FEP) ☐ Medicaid ☐ Medicare Advantage ☐ Blue Community^{SM} HMO ☐ Blue Advantage HMO Network^{SM}

Are you associated with: ☐ IPA (Independent Physician Association) Name: _____

☐ PHO (Physician Hospital Organization) Name: _____

Group/Company Name: _____

Specialty or type of Group/Company: _____

Type 2 NPI: _____ Tax Identification Number (TIN): _____

Employer Identification Number (EIN): _____

Is this your personal taxpayer number? Yes ☐ No ☐

Does it belong to a Corporation, partnership, etc.? Yes ☐ No ☐

Physical Address

(attach a separate sheet for any additional addresses **with phone numbers, office hours and services performed**)

Address: _____

City: _____ State: _____ Zip: _____ County: _____

Phone #: _____ Fax #: _____

Email address: _____

Contact name: _____ Phone # _____

Office days and hours: _____

Services performed at this location: _____

Billing/Payee Address (Mail Check To)

Address: _____

City: _____ State: _____ Zip: _____ County: _____

Phone #: _____ Fax #: _____

Email address: _____

Contact name: _____ Phone # _____

Mailing/Correspondence Address

Address: _____

City: _____ State: _____ Zip: _____ County: _____

Phone #: _____ Fax #: _____

Email address: _____

Contact name: _____ Phone # _____

Continued on next page

Group Information (continued)

Practice Information
Are you currently a Medicaid provider in New Mexico? Yes ☐ No ☐ Medicaid number: _____
Does this facility have wheelchair access? Yes ☐ No ☐
Does the physical location provide screening mammography services? Yes ☐ No ☐ Scheduling Phone Number:
Do you or your staff speak other languages? Yes ☐ No ☐ If yes, which languages:
Comments or additional information you would like to provide:

To the best of my knowledge, the information supplied on this document is accurate and complete. Upon submission of this application, group provider hereby releases this information to Blue Cross and Blue Shield of New Mexico for the purpose of establishing a BCBSNM Group Provider Record.

Please complete all information above. This form will be returned if incomplete.

Attach a copy of:

- ☐ State Medical License
- ☐ Letter 147C
- ☐ Hospital Coverage Letter
- ☐ Medicare and/or Medicaid certification letters (if applicable)

Provider Disclosure of Ownership and Control Interest Form - If you are applying for the Medicaid network, complete and submit this form as part of the complete application packet.

For internal use only.

BlueCross BlueShield of New Mexico

Practitioner Information

Please complete for each practitioner in the group

Group Name:
TIN/EIN:

Practitioner Information:		
Name (First, Middle, Last, Title/Degree):		
Specialty:	Sub-specialty:	
Date of Birth:	Gender: Male ☐ Female ☐	
Applying as: Primary Care Physician ☐ Specialist ☐ Other Health Care Professional Providers ☐		
Are you currently a Medicare provider in New Mexico? Yes ☐ No ☐ Medicare PTAN: _____		
Are you currently a Medicaid provider in New Mexico? Yes ☐ No ☐ Medicaid number: _____		
Practice Location:		
City	State	Zip
Phone #:	Fax #:	
Email:		
Social Security Number:	Type 1 NPI:	
State License #: *(If temporary, attach copy)*	Effective Date:	
Effective date of joining the group:	Any limitations to practice:	
For CRNAs Only - AANA Certification #: Effective Date:		
CAQH Provider ID:		
Do you speak other languages? Yes ☐ No ☐ If yes, which languages:		
List admitting hospital privileges (if applicable)		

Have you ever been convicted of a felony or fraud?	Yes ☐ No ☐
Has your license to practice medicine in any jurisdiction ever been suspended or revoked?	Yes ☐ No ☐
Does your physical/mental health limit you in any way from performing your duties as a physician?	Yes ☐ No ☐
While practicing medicine, have you ever been impaired by alcohol or other chemical substances?	Yes ☐ No ☐
Have your privileges at any hospital ever been restricted, revoked, or not renewed?	Yes ☐ No ☐
Have you ever been listed on an OIG or other government sanction list?	Yes ☐ No ☐

If you answered *yes* to any of the above questions, please include a detailed letter of explanation.

Please complete all of the information above. This form will be returned if incomplete.

Attach a copy of each provider's

☐ **State Medical License (required)**

☐ **Federal DEA license and the State controlled Substance registration**

☐ **W-9 form**

BlueCross BlueShield of New Mexico

HOSPITAL COVERAGE LETTER

To: Blue Cross and Blue Shield of New Mexico (BCBSNM)

Date: _____

Please accept this correspondence as confirmation that since I do not have active admitting privileges at a participating network hospital (in the applicable BCBSNM provider network(s) in which I participate), with the exception of medical emergencies, my practice will be confined to outpatient care.

I hereby agree and attest, that if non-emergency hospitalization is necessary, I will refer BCBSNM subscriber/member care to a participating physician or hospitalist (in the applicable BCBSNM provider network) who has active admitting privileges at a participating network hospital (in the applicable BCBSNM provider network).

(Please print legibly or complete online)

Provider's Name:
_____

Provider's NPI #:
_____

Provider's Signature:
_____

BCBSNM provider networks include:
1) Commercial: HMO/PPO 2) Medicaid 3) Medicare Advantage 4) Blue Community[SM] HMO
5) Blue Advantage HMO Network[SM]

Note: *If you are unsure of the participation status of a specific BCBSNM provider network, for yourself, another physician, hospitalist, or hospital, please contact Network Services office by fax or phone*.

Provider Relations Office	FAX Number	Telephone Number
Network Services	505-816-2688/1-866-290-7718	505-837-8800/1-800-567-8540

BlueCross BlueShield of New Mexico

Provider Disclosure of Ownership and Control Interest Form

This form is for groups, organizations or individuals directly contracted with Blue Cross and Blue Shield of New Mexico (BCBSNM) to whom or which payments will be made ("**Disclosing Provider**"). Such Disclosing Provider should please collect the information set forth in this form and return it to BCBSNM once completed and signed. Individual providers who bill for services through a group practice or organization contracted with BCBSNM need **not** separately or individually complete this form. Regulatory definitions may be found at 42 CFR Sections 101, et seq.

Name of Disclosing Provider (Directly Contracted with BCBSNM)	Tax ID Number	NPI

1. CRIMINAL CONVICTIONS (42 CFR Section 455.106)

Has the Disclosing Provider, or any "person who has ownership or control interest" in the Disclosing Provider, or any person who is an "agent" or "managing employee" of the Disclosing Provider, been convicted of a **CRIMINAL OFFENSE** related to that person's involvement in any program under Medicare, Medicaid, or the Title XX (Block Grants to States for Social Services) since the inception of those programs? (Definitions may be found at 42 CFR Sections 101, *et seq.*). If yes, give the name(s) of person(s) and description(s) of offense(s). Please use additional pages if necessary.

Name of Criminal Offender	TIN or SSN	Date of Birth	Description of Offenses

2. MANAGING EMPLOYEES (42 CFR Section 455.104(b)(4))

Definition: A managing employee is a "general manager, business manager, administrator, director or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operations of an institution, organization, or agency." Managing employees are in a position to exert influence over the conduct of the Disclosing Provider's operations and includes officers, governing boards, or board of directors.

New Mexico Human Services Department, Medical Assistance Division requires the following information to be disclosed on all managing employees of the disclosing provider. Please use additional pages if necessary.

Name of Managing Employee	SSN	Address(es)	Date of Birth

3. OWNERSHIP AND CONTROL (42 CFR Section 455.104(b)(i)(ii) and (iii))

Definitions: Person with an ownership or control interest generally means a person or corporation that (i) has an ownership interest of at least 5 percent in the Disclosing Provider; or (ii) is an officer or director of, or partner in, the Disclosing Provider. Ownership means possession of equity in the capital, stock, or profits of the Disclosing Provider. The 5 percent ownership threshold may be met by direct or indirect ownership, or combination of the two. Indirect ownership means an ownership interest in an entity that has an ownership Interest in the Disclosing Provider.

Provide the name and address of each person (i) with an ownership or control interest in the Disclosing Provider or, (ii) in any subcontractor in which the Disclosing Provider has direct or indirect ownership of five percent or more. For corporations that have an ownership or control interest in the Disclosing Provider, please separately list its primary business address, every business location and post office box address. Please use additional pages if necessary.

Name of Person with Ownership or Control Interest	TIN or SSN	Address(es)	Date of Birth

4. OWNERSHIP AND CONTROL – RELATIVES (42 CFR Section 104(b)(2))

Is any person named in question #3 related to another person also named in question #3 as spouse, parent, child, or sibling? If yes, give the name(s) of person(s) and relationship(s). Please use additional pages if necessary.
***Note**: Designate relationship to each person listed in question #3.*

Name of Responsive Person from Question #3, if any	Relationship to Other Person from Question #3, if any

5. OWNERSHIP AND CONTROL – OTHER PROVIDERS AND ENTITIES (42 CFR Section 455.104(b)(3))

Does any person named in question #3 have an ownership or control interest in any other Medicaid provider or in any entity that does not participate in Medicaid but is required to disclose certain ownership and control information because of participation in any of the programs established under Title V (Maternal and Child Health Services Block Grant), XVII (Grants for Planning Comprehensive Action to Combat Mental Retardation), or XX (Block Grants to States for Social Services) of the Social Security Act? If yes, give the name(s), Medicaid provider identification number(s) and address(es) of the Medicaid provider or entity. Please use additional pages if necessary.

Name of Responsive Person from Question #3, if any	Address(es)	Medicaid Provider ID Number

Certification:

I certify that the above disclosed information is true and correct to the best of my knowledge as of the date set forth below. I further understand that payment of claims will be from Federal and State funds and that any falsification or concealment of a material fact may be prosecuted under Federal and State Law.

Signature **Date**

Title

Printed name

Return your completed form to:
Blue Cross and Blue Shield of New Mexico
Attn: Network Services Department
P.O. Box 27630
Albuquerque, NM 87125-7630

Or Fax to: 1-866-290-7718 or 505-816-2688