Practitioner Enrollment Form

PLEASE:

1. **Complete the application in its entirety.**
2. **No handwritten forms; please type.**
3. **This cover sheet must be the first page of your form submission.**
4. **Fax the enrollment form and attachments (i.e. supporting documents) to 1-855-306-9762 or email to bccproviderdata@mibluecrosscomplete.com. Be sure to submit the enrollment form separately for each provider. (For example: If you register two or more providers, you must send a fax/email for each provider. They cannot be bundled into one transmission.)**
5. **You can also mail the completed forms and documentation to: Blue Cross Complete of Michigan, Provider Network Management, 100 Galleria Officentre, Suite 210, Southfield, MI 48034**
6. **Supporting documents checklist is located at the end of the enrollment form. Please review and ensure all required documents are submitted along with this enrollment form.**

Note: You are required to complete and maintain a credentialing application through the Council for Affordable Quality Healthcare® at https://upd.caqh.org/oas/.* In order for your Blue Cross Complete affiliation request to be processed, you **must complete your CAQH application** within 14 calendar days. If you have already completed the CAQH application, your attestation must be up to date. If your CAQH application is not complete or if your attestation is expired after 14 calendar days, your request will be closed and you will need to reapply once updated.

Fax to:	**1-855-306-9762** Attn: Provider Network Management
Email to:	**BCCproviderdata@mibluecrosscomplete.com**
From:	
Date:	
Type 1 NPI:	
Type 2 NPI:	
State License Number:	
Is the provider already enrolled with Blue Cross Blue Shield of Michigan or Blue Care Network?	**Yes** ☐ **No** ☐
If "No", please be advised you will be provided additional forms for completion and this may delay the enrollment process	

*Blue Cross Complete does not control this website and is not responsible for its content

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Practitioner Enrollment Form

State license number	Type 1 NPI	Type 2 NPI

Section 1: Demographic information

* denotes required field

1. *First name		2. *Last name	
3. Middle name		4. Suffix (Jr., Sr., II,)	
5. *Degree or title		6. Gender	
7. *CAQH ID number		8. *Date of birth (MM/DD/YYYY)	
9. Ethnicity		10. * Social Security Number	
11. Languages spoken other than English		12. Other names you may have used (Maiden, a.k.a., etc.)	

Section 2: Practice specialty for which you are seeking affiliation

1. *Provider type	Primary Care Practitioner ☐	Specialist ☐
2. *Specialty		
3. *Board certified (M.D., D.O., D.M.D., D.P.M., D.D.S. only)	Yes ☐	No ☐
4. *Board eligible (M.D., D.O., D.M.D., D.P.M., D.D.S. only)	Yes ☐	No ☐
5. Do you practice exclusively in a hospital setting? (if "Yes", Section 1 of the CAQH must be updated to reflect hospital based status)	Yes ☐	No ☐

Section 3: Mid-level and Allied Health practitioner supervising physicians

1. Supervising physician name	
2. Supervising physician specialty	
3. Supervising physician NPI	

Section 4: Medical Care Group or Independent Physician Association Affiliation

1. Please provide the name of the medical care group or independent physician association and number you wish to join (required for PCPs)	
a. Medical Care Group name	
b. Medical Care Group number (begins with an "IH")	

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Practitioner Enrollment Form

State license number	Type 1 NPI	Type 2 NPI

Section 5: Primary office practice information

* denotes required field

1. Primary office address (must be an address where health care services are rendered and may be published in the Blue Cross Complete provider directory, Primary Care Practitioners must practice a minimum of 20 hours per week, per location)	
a. *Group practice name (as it appears on W-9 /SS4 form)	
b. *Federal tax ID	
c. *Tax exempt	☐ Yes ☐ No
d. *Street address	
e. *City	
f. *State	
g. *Zip code	
h. County	
i. *Primary telephone number	
j. Fax number	
2. Payment or remit Address (if different from your primary address)	
a. Street address	
b. City	
c. State	
d. Zip code	
3. Mailing address (if different from your primary address)	
a. Street address	
b. City	
c. State	
d. Zip code	
4. Medical Records Request (MMR) (if different from your primary address)	
a. Street address	
b. City	
c. State	
d. Zip code	

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Practitioner Enrollment Form

State license number	Type 1 NPI	Type 2 NPI

Section 5: Primary office practice information - continued

* denotes required field

5. *Office hours		
	From	**To**
a. Monday		
b. Tuesday		
c. Wednesday		
d. Thursday		
e. Friday		
f. Saturday		
g. Sunday		

6. Waiting times (in days)	
a. Routine visits	
b. Well exams	
c. Urgent problems	

7. Panel information		
a. Do you place an age limit on your patients?	Minimum age:_____	Maximum gge:_____
b. Accepting new patients into the practice?	☐ Yes	☐ No
c. Accepting existing patients only?	☐ Yes	☐ No
d. Place limitation on patient gender?	☐ Male	☐ Female

8. Contact information – please provide the name and contact information of a person who can answer questions about information in this enrollment form	
a. *Contact name	
b. *Telephone number	
c. *Email address	

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Practitioner Enrollment Form

State license number	Type 1 NPI	Type 2 NPI

Section 6: Secondary office practice information

* denotes required field

1. Secondary office address (must be an address where health care services are rendered and may be published in the Blue Cross Complete provider directory)	
a. *Group practice name (as it appears on W-9 /SS4 form)	
b. *Federal tax ID	
c. *Tax exempt	☐ Yes ☐ No
d. *Street address	
e. *City	
f. *State	
g. *Zip code	
h. County	
i. *Primary telephone number	
j. Fax number	
2. Payment or remit address (if different from your secondary address)	
e. Street address	
f. City	
g. State	
h. Zip code	
3. Mailing address (if different from your secondary address)	
e. Street address	
f. City	
g. State	
h. Zip code	
4. Medical Records Request (MMR) (if different from your secondary address)	
e. Street address	
f. City	
g. State	
h. Zip code	

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Practitioner Enrollment Form

State license number	Type 1 NPI	Type 2 NPI

Section 6: Secondary office practice information - continued

* denotes required field

5. *Office hours		
	From	**To**
h. Monday		
i. Tuesday		
j. Wednesday		
k. Thursday		
l. Friday		
m. Saturday		
n. Sunday		

6. Waiting times (in days)	
d. Routine visits	
e. Well exams	
f. Urgent problems	

7. Panel information		
a. Do you place an age limit on your patients?	Minimum age:_____	Maximum age:_____
b. Accepting new patients into the practice?	☐ Yes	☐ No
c. Accepting existing patients only?	☐ Yes	☐ No
d. Place limitation on patient gender?	☐ Male	☐ Female

8. Contact information – please provide the name and contact information of a person who can answer questions about information in this enrollment form	
d. *Contact name	
e. *Telephone number	
f. *Email address	

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Practitioner Enrollment Form

Section 7: Enrollment signature

* denotes required field

I certify that the information contained in this application is true and complete and the accompanying documents are correct and complete to the best of my knowledge and belief. If this enrollment form contains any material omission or false or misleading information, I understand that participation with Blue Cross Complete may be rejected or terminated. I further understand that a copy of these statements shall be as binding as the original.

I will notify Blue Cross Complete of Michigan immediately in writing of changes affecting this data. If I am a practitioner in training, I will not report services that are related to my training program and rendered at the address from which I am training. Should I re-enter training, I will notify Blue Cross Complete of Michigan.

I hereby authorize Blue Cross Complete to verify the information provided on this application and accompanying documentation through contracting, credentialing, recredentialing or reappointment activity of Blue Cross Complete.

*Print or type Name	*Practitioner signature or title	*Date

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Practitioner Enrollment Form

Provider enrollment required document checklist

Provider classification	To avoid processing delays, please ensure all items are submitted
Anesthesia assistant	• Type 1 National Provider Identifier • Social security number • Tax identification number and Internal Revenue Service document identifying TIN and associated payee name • Supervising physician
Audiologist	• Type 1 National Provider Identifier • Social security number • Tax identification number and Internal Revenue Service document identifying TIN and associated payee name • State of Michigan professional license number • Council for Affordable Quality Healthcare number (if available)
Board certified behavior analyst	• Behavior analyst board certification • Type 1 National Provider Identifier • Social security number • Tax identification number and Internal Revenue Service document identifying TIN and associated payee name • State of Michigan professional license number • Council for Affordable Quality Healthcare number (if available)
Certified nurse midwife	• Type 1 National Provider Identifier • Social security number • Tax identification number and Internal Revenue Service document identifying TIN and associated payee name • State of Michigan professional license number • Council for Affordable Quality Healthcare number (if available) • Certification from the American College of Certified Nurse Midwives • For CNMs performing deliveries, the following are also required: ▪ Written confirmation of established privileges with hospitals or has hospital-affiliated birthing centers • Written confirmation of an established, interdependent relationship for medical consultation or collaboration or referral to an OB/GYN

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Practitioner Enrollment Form

Provider classification	To avoid processing delays, please ensure all items are submitted
Certified nurse practitioner	• Type 1 National Provider Identifier • Social security number • Tax identification number and Internal Revenue Service document identifying TIN and associated payee name • State of Michigan professional license number • Council for Affordable Quality Healthcare number • Certification from one of the following national entities with effective and expiration dates: ▪ American Nurse Credentialing Center ▪ National Certification Corporation for the Obstetrics/Gynecology and Neonatal Specialties ▪ National Certification Board of Pediatric Nurse Practitioners and Nurses ▪ Nurse Practitioner Program of the United States Department of Health and Human Services ▪ The Oncology Nursing Certification Program
Certified registered nurse anesthetist	• Certification from one of the following entities with effective and expiration dates: ▪ National Board of Certification & Recertification for Nurse Anesthetists ▪ Certification from the Council on Certification of Nurse Anesthetists ▪ Certification from the Council on Recertification of Nurse Anesthetists • State of Michigan professional license • Type 1 National Provider Identifier • Social security number • Tax identification number and Internal Revenue Service document identifying TIN and associated payee name • Council for Affordable Quality Healthcare number
Chiropractor	• Type 1 National Provider Identifier • Social security number • Tax identification number and Internal Revenue Service document identifying TIN and associated payee name • State of Michigan professional license number • Council for Affordable Quality Healthcare number
Certified nurse specialist	• Type 1 National Provider Identifier • Social security number • Tax identification number and Internal Revenue Service document identifying TIN and associated payee name • State of Michigan professional license number • Council for Affordable Quality Healthcare number
Doctor of medicine	• Type 1 National Provider Identifier • Social security number • Tax identification number and Internal Revenue Service document identifying TIN and associated payee name • State of Michigan professional license number • Council for Affordable Quality Healthcare number

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Practitioner Enrollment Form

Provider classification	To avoid processing delays, please ensure all items are submitted
Hearing aid dealer	• Type 1 National Provider Identifier • Social security number • Tax identification number and Internal Revenue Service document identifying TIN and associated payee name • State of Michigan professional license number • Council for Affordable Quality Healthcare number (if available)
Independent occupational or physical therapist	• Type 1 National Provider Identifier • Social security number • Tax identification number and Internal Revenue Service document identifying TIN and associated payee name • State of Michigan professional license number • Council for Affordable Quality Healthcare number (if available) • Medicare approval letter
Independent speech language pathologist	• Type 1 National Provider Identifier • Social security number • Tax identification number and Internal Revenue Service document identifying TIN and associated payee name • State of Michigan professional license number • Council for Affordable Quality Healthcare number (if available) • Certificate of clinical competence from the American Speech-Language Hearing Association • Medicare approval letter
Licensed Master of social worker	• Type 1 National Provider Identifier • Social security number • Tax identification number and Internal Revenue Service document identifying TIN and associated payee name • State of Michigan professional license number • Council for Affordable Quality Healthcare number (if available)
Licensed professional counselor	• Type 1 National Provider Identifier • State of Michigan professional license • Social Security Number • Tax identification number and Internal Revenue Service document identifying TIN and associated payee name • Council for Affordable Quality Healthcare number (if available)
Ophthalmologist	• Type 1 National Provider Identifier • Social security number • Tax identification number and Internal Revenue Service document identifying TIN and associated payee name • State of Michigan professional license number • Council for Affordable Quality Healthcare number (if available)

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Practitioner Enrollment Form

Provider classification	To avoid processing delays, please ensure all items are submitted
optician or optical Supplier	• Type 2 National Provider Identifier • Tax identification number and Internal Revenue Service document identifying TIN and associated payee name
Optometrist	• Type 1 National Provider Identifier • Social security number • Tax identification number and Internal Revenue Service document identifying TIN and associated payee name • State of Michigan professional license number • Council for Affordable Quality Healthcare number (if available)
Oral surgeon	• Type 1 National Provider Identifier • Social security number • Tax identification number and Internal Revenue Service document identifying TIN and associated payee name • State of Michigan professional license number • Council for Affordable Quality Healthcare number (if available)
Physician assistant	• Type 1 National Provider Identifier • Tax identification number and Internal Revenue Service document identifying TIN and associated payee name • State of Michigan professional license number • Council for Affordable Quality Healthcare number (if available) • Supervising physician
Podiatrist	• Type 1 National Provider Identifier • Social security number • Tax identification number and Internal Revenue Service document identifying TIN and associated payee name • State of Michigan professional license number • Council for Affordable Quality Healthcare number
Psychiatrist	• Type 1 National Provider Identifier • Social security number • Tax identification number and Internal Revenue Service document identifying TIN and associated payee name • State of Michigan professional license number • Council for Affordable Quality Healthcare number

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Practitioner Enrollment Form

Provider classification	To avoid processing delays, please ensure all items are submitted
Psychologist (fully licensed)	• Type 1 National Provider Identifier • Social security number • Tax identification number and Internal Revenue Service document identifying TIN and associated payee name • State of Michigan professional license number • Council for Affordable Quality Healthcare number (if available)

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MEDICAL SERVICE AGREEMENT

MCG PRACTITIONER AFFILIATION ACKNOWLEDGEMENT

This Acknowledgement is effective _____ (Date to be entered only by Health Plan), by and between **Blue Cross Complete of Michigan** (hereinafter "**Health Plan"**), **BEAUMONT ACO**, a Medical Care Group or MCG (hereinafter "**Provider"**) and _____ (hereinafter **"Practitioner")**.

1. **Provider Contracting Authority**- For the purposes of providing health care services to Members and in consideration of the mutual promises of the parties to the Medical Service Agreement ("**Agreement**"), Provider and Practitioner represent that Practitioner is contracted with Provider and that Provider is duly authorized and empowered to contract on Practitioner's behalf for the purpose of binding Practitioner to the terms and conditions of the Agreement.

2. **Agreement**- Practitioner warrants that he/she has received and read the Health Plan Medical Service Agreement between Health Plan and Provider, which is incorporated herein by reference, and agrees to be bound by the terms and conditions contained in the Agreement. The Agreement, this Acknowledgement, and the Health Plan Provider Manual constitute the entire Agreement between Health Plan, Provider, and Practitioner. Practitioner is fully aware of the responsibilities and requirements pertinent to his/her designated role as Specialist Practitioner or Primary Care Practitioner under the Agreement. Provider and Practitioner agree to abide by the terms and conditions set forth in the Agreement, this Acknowledgement, and all amendments or modifications thereto.

3. **Identifying Information**- Upon execution of this Acknowledgement, Provider shall provide to Health Plan on at least an annual basis the required identifying information for Practitioner. Such information shall be provided and periodically updated by Provider in such detail and format as necessary for Health Plan to maintain accurate provider enrollment records.

BEAUMONT ACO

_____
Signature

_Walter Lorang_____
Name (print or type)

_Executive Director_____
Title

_____
Date

BLUE CROSS COMPLETE

_____
Signature

_Donald Beam MD_____
Name (print or type)

_Chief Medical Officer_____
Title

_____
Date

PRACTITIONER

_____
Signature

_____
Name (print or type)

_____
Title

_____
Date

MCG PRACTITIONERS APPLICABLE GROUP PRACTICE INFORMATION

_____
Group Practice NPI number

_____
Group Practice Tax ID Number

Specialist Physicians Only: Specialists who are solo practitioners will have applicable withholds applied towards claims submitted with the individual Tax ID and Type I NPI listed above. Specialists who are part of a practice group acknowledge the following tax ID and Type II NPI numbers are accurate and appropriate for all billing with respect to this Acknowledgement. Please list applicable practice group Tax ID and their associated Type II NPI numbers:

Group Tax ID#:_____ Group Type II NPI:_____

Group Tax ID#:_____ Group Type II NPI:_____

Group Tax ID#:_____ Group Type II NPI:_____

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.*