Instructions for fax cover sheet

We cannot accept handwritten forms. Do not hand write anywhere on the forms, otherwise processing will be delayed.

To ensure forms are processed timely, please adhere to the following instructions:

- **For individual practitioners**
  - From (Insert name of contact person)
  - Date (mm/dd/yyyy)
  - Type 1 NPI (National Provider Identifier)
  - State license number
  - When adding an individual to an existing group, be sure to fax a group change form

- **For allied providers**
  - From (Insert name of contact person)
  - Date (mm/dd/yyyy)
  - Type 2 NPI (National Provider Identifier)
  - Tax identification number

- **For professional group practices and facilities**
  - From (Insert name of contact person)
  - Date (mm/dd/yyyy)
  - Type 2 NPI (National Provider Identifier)
  - Tax identification number

Instructions for document submission

1. Fax cover sheet must be the first page of your form submission.

2. Fax the registration form and attachments (i.e., signature documents) to **1-866-900-0250**. Be sure to fax the registration information separately for each provider. (For example: If you register two or more providers, you must send a fax for each provider. They cannot be bundled into one fax transmission.)

Questions? Call 1-800-822-2761

FAX COVER SHEET FOR DOCUMENTS

IMPORTANT: Attach this page to the top of your document to avoid processing delays.

Fax To: **866-900-0250 Provider Enrollment**

From:

Date:

Form Number: 10578

Type 1 NPI:

Type 2 NPI:

State License Number:

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MENTAL HEALTH PRACTITIONER CHANGE FORM

State license number	Type 1 National provider identifier	Type 2 National provider identifier

If you are a MD, DO, DC, DPM, DMD/DDS (Board certified oral surgeon only), independent physical therapist, independent occupational therapist or independent speech language pathologist, use this form to:

- Provider Race / Ethnicity Information - Section 1
- Change Medicare / PTAN number, EIN/Tax ID number and/or name - Section 2
- Request additional networks - Section 3
- Request to terminate networks - Section 4
- Change BCBSM particpation status - Section 5
- Change remit, mailing and/or medical records address - Sectin 6
- Change behavioral health services - Section 7
- End practitioner's relationship with a group - Section 8
- Change Type 1 NPI - Section 9
- Contact Information - Section 10
- Application Signature - Section 11

The following fields must be changed through the CAQH at **https://proview.caqh.org/pr**

- First name
- Middle name
- Last name
- Suffix
- Date of birth
- SSN
- Primary address
- Specialty / Board certification
- Add / End practice locations

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MENTAL HEALTH PRACTITIONER CHANGE FORM

State license number	Type 1 National provider identifier	Type 2 National provider identifier

Section 1: Demographic Data

*denotes a required field

Race/Ethnicity

- ☐ White/Caucasian
- ☐ Black or African American
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Chinese/Chinese-American
- ☐ Filipino
- ☐ Japanese/Japanese-American
- ☐ Korean
- ☐ Vietnamese
- ☐ Native Hawaiian or other Pacific Islander
- ☐ Mexican/Mexican-American
- ☐ Hispanic/Latin American
- ☐ Arab
- ☐ Other Race
- ☐ Assyrian/Chaldean
- ☐ Other Asian
- ☐ Multiracial
- ☐ Not Disclosed

Section 2: Change in Individual EIN/TAX ID Number and/or tax name

Note: Tax information in this section updates the individual practitioner's SSN or personal EIN for an incorporated indivdual business.

- You must also update your payment and remittance address on CAQH
- Include IRS Form 147c or an IRS Tax Deposit Coupon.

EIN / Tax ID number			
EIN / Tax ID name as indicated on Internal Revenue Service document			
Tax exempt: ☐ Yes ☐ No		Effective date	
Medicare / PTAN number			

If you are a practitioner joining a group, the group's Tax Id information needs to be added via a **New Group Enrollment form** for a new group or, a **Group Change form** for an existing group.

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State license number	Type 1 National provider identifier	Type 2 National provider identifier

Section 3: Request additional networks

If you are applying for a managed care network, you must complete your **Council for Affordable Quality Healthcare® (CAQH) application within 14 calendar days**. If you have already completed CAQH, 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.

You will be notified of your status and the effective dates of affiliation in BCBSM and BCN managed care networks after credentialing for the networks is completed and BCBSM and BCN has counter-signed your affiliation agreements. **Important:** Along with this application, it is necessary to complete and submit the signature document appropriate for your provider type. For each network you wish to participate in, be sure to place a check mark by the appropriate affiliation agreement, sign the signature document, and submit it along with this form.

Provider Type	Eligible Networks for Provider Type
Licensed Behavior Analyst (to treat patients with autism spectrum disorder only)	☐ Traditional-Participating ☐ Traditional-Nonparticipating ☐ BCN Commercial
Certified Nurse Practitioner	☐ Traditional-Participating ☐ Traditional-Nonparticipating ☐ BCBSM Mental Health and Substance Abuse Managed Care Network ☐ Medicare Advantage℠ PPO
Clinical Nurse Specialist Certified	☐ Traditional-Participating ☐ Traditional-Nonparticipating ☐ BCBSM Mental Health and Substance Abuse Managed Care Network ☐ Medicare Advantage℠ PPO TRUST PPO
Licensed Professional Counselor	☐ Traditional-Participating ☐ Traditional-Nonparticipating ☐ BCBSM Mental Health and Substance Abuse Managed Care Network ☐ TRUST PPO
Licensed Marriage and Family Therapist Limited Licensed Psychologist	☐ Traditional-Participating ☐ Traditional-Nonparticipating
Clinical Licensed Master Social Worker	☐ Traditional-Participating ☐ Traditional-Nonparticipating ☐ BCBSM Mental Health and Substance Abuse Managed Care Network ☐ Medicare Advantage℠ PPO ☐ TRUST PPO
Fully Licensed Psychologist Psychiatrist	☐ Traditional-Participating ☐ Traditional-Nonparticipating ☐ BCN Commercial ☐ BCBSM Mental Health and Substance Abuse Managed Care Network ☐ BCN Advantage℠ HMO ☐ Medicare Advantage℠ PPO ☐ TRUST PPO

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MENTAL HEALTH PRACTITIONER CHANGE FORM

State license number	Type 1 National provider identifier	Type 2 National provider identifier

Section 4: Request to terminate networks

Note: If you are terminating all networks, please complete the Practitioner Termination Form.

Requested termination date - The actual date of your termination will be determined based on the provisions in the applicable participation agreements.

Select networks you are terminating:

BCBSM Networks	Requested termination date
TRUST PPO	☐ Date:
BCBSM Mental Health and Substance Abuse Managed Care Network	☐ Date:
Medicare Advantage℠ PPO	☐ Date:
BCN Networks	**Requested terminatin date**
BCN Commercial	☐ Date:
BCN Advantage℠ HMO	☐ Date:

Section 5: Change BCBSM participation status

BCBSM Networks	Requested participation change	
Traditional	☐ Non-participating to Participating ☐ Participating to Non-participating (effective 60 days upon receipt of request)	Date:

MENTAL HEALTH PRACTITIONER CHANGE FORM

State license number	Type 1 National provider identifier	Type 2 National provider identifier

Section 6: Change remit/mailing and/or medical records address

Payment/Remit address		
Effective date		
Street Address		
City	State	Zip Code

Mailing address		
Effective date		
Street Address		
City	State	Zip Code

Medical Records Request (MRR)		
Street Address		
City	State	Zip Code
Contact Name - First	Middle	Last
Telephone	Fax	Email

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MENTAL HEALTH PRACTITIONER CHANGE FORM

State license number	Type 1 National provider identifier	Type 2 National provider identifier

Section 7: Change behavioral health services

Select Age Ranges Treated:

☐ 0-12 (Child) ☐ 3-17 (Adolescent) ☐ 18-64 (Adult) ☐ 65+ (Geriatric) **Other:** _____

Check Counseling Services Provided		
Mental Health Outpatient Services	☐ Add	☐ Remove
Substance Use Outpatient Services	☐ Add	☐ Remove

In an effort to help us match patient need to available providers, please identify **a maximum of five (5)** speciality areas of interest or certification. We will use this information in directing members for specific services.

Our expectation is that your practice is open and accepting new cases if you indicate specialities below.

Select Five (5) Total					
High Need Expertise	**Add**	**Remove**		**Add**	**Remove**
Autism	☐	☐	Neuropsychological Testing	☐	☐
Dementia/Alzheimer's	☐	☐	Pain Managment	☐	☐
Disorders of Childhood & Adolescence	☐	☐	Personality Disorders	☐	☐
Dissociative Disorders	☐	☐	Psychological Testing	☐	☐
Eating Disorders	☐	☐	Psychotic Disorders	☐	☐
Exposure Response Prevention Therapy	☐	☐	Traumatic Brain Injury	☐	☐
Additional Special Areas	**Add**	**Remove**		**Add**	**Remove**
ADD / ADHD	☐	☐	LGBT Issues	☐	☐
Bereavement/Grief/Loss	☐	☐	Medication Assisted Treatment for Opioid Use (MATO)*	☐	☐
Bariatric	☐	☐			
Brief Dynamic Therapy	☐	☐	Obsessive Compulsive Disorders	☐	☐
Cognitive Behavioral Therapy	☐	☐	Outpatient Transcrania Magnetic Stimulation	☐	☐
Dialectical Behavioral Therapy	☐	☐			
Eye Movement Desensitization Reprocessing	☐	☐	Phobias	☐	☐
			Post Traumatic Stress Disorder	☐	☐
Gambling Addiction	☐	☐	Sexual Addiction	☐	☐
Gender/Transgender Identification	☐	☐	Sexual Dysfunction	☐	☐
HIV / AIDS	☐	☐	Spending Addiction	☐	☐
Interpersonal Therapy	☐	☐	Suboxone Treatment Opiate Addicition (STOA)*	☐	☐

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MENTAL HEALTH PRACTITIONER CHANGE FORM

State license number	Type 1 National provider identifier	Type 2 National provider identifier

Section 8: End practitioner's relationship with a group

Identify group(s) you are no longer affiliated with as a practitioner.

Group Name	Type 2 NPI	Effective date of termination
Check here if physiciains were acting as a BCN PCP		

If you have additional practice locations that you want to Add/Remove, please list and attach separately.

Section 9: Change Type 1 National Provider Identification

Previous Type 1 NPI	
New Type 1 NPI	
Reason for change	

Section 10: Contact information

*denotes a required field

Contact information (Please provide the name and contact information of a person who can answer questions about information in this application)			
*First name			Last name
*Telephone number	extension		Fax number
Work e-mail address			Preferred method of contact? ☐ Email ☐ US Mail

Section 11: Application signature

*denotes a required field

I certify that the information contained in this application is true and complete. I will notify Blue Cross and Blue Shield of Michigan and Blue Care Network 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 BCBSM and BCN.

For providers applying to be Traditional non-participating providers, the authorized signer agrees on behalf of itself and the provider on whose behalf the authorized signer is acting, to adhere to BCBSM's Billing Guidelines for Non-Participating Providers. These Guidelines include, without limitation, the requirement to permit BCBSM or its designee physical access to the provider's premises to review and/or copy for any permissible purpose any and all medical and billing records submitted by the provider or its billing agent, and the requirement that the provider accept BCBSM's payment as payment in full for services rendered to a BCBSM member when the provider has indicated that it will accept assignment of payment on the member's behalf, will participate with BCBSM on a particular claim, or has otherwise indicated that he/she wishes to receive payment directly from BCBSM and, with the exception of any applicable deductibles, co-payments, or co-insurance amount, not balance bill the member for the difference between BCBSM's payment and the provider's charged amount.

*Print or Type Name	*Authorizing Signature/Title	*Date