

QR code for BCBSM Internal use only

Instructions for document completion

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:

Enter all information online; press the tab key  after each entry to move from field to field.

■ 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

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



NEW MENTAL HEALTH PRACTITIONER ENROLLMENT

State license number	Type 1 National Provider Identifier
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Please complete this form if you are a psychiatrist, fully licensed psychologist, clinical licensed master's social worker, licensed professional counselor, licensed behavior analyst, licensed marriage and family therapist, limited licensed psychologist, certified nurse practitioner or clinical nurse specialist certified applying to Blue Cross Blue Shield of Michigan and Blue Care Network for the first time.

Note: Your provider type is required to complete and maintain a credentialing application through the Council for Affordable Quality Healthcare® at <https://proview.caqh.org/pr>. In order for your managed care affiliation request to be processed you must **complete your CAQH application within 14 calendar days**. If you have already completed a 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 using the [Mental Health Practitioner Change form](#).

Section 1: Demographic Data

*denotes a required field

*First name		Middle name							
*Last name		Suffix	II	III	IV	Jr.	Sr.		
*What type of provider are you?	MD - psychiatrist	DO - psychiatrist							
	fully licensed psychologist	clinical nurse specialist certified							
	clinical licensed master's social worker	licensed behavior analyst (to treat patients with autism spectrum disorder only)							
	licensed professional counselor	certified nurse practitioner							
	licensed marriage and family therapist								
limited licensed psychologist									
*County where your primary address is located									
*Degree						*Date of birth			
Gender:	Male	Female	Preferred salutation:		Dr.	Ms.	Mrs.	Mr.	Miss
Race / Ethnicity									
White/Caucasian					Native Hawaiian or other Pacific Islander				
Black or African American					Mexican/Mexican-American				
American Indian or Alaska Native					Hispanic/Latin American				
Asian					Arab				
Chinese/Chinese-American					Other Race				
Filipino					Assyrian/Chaldean				
Japanese/Japanese-American					Other Asian				
Korean					Multiracial				
Vietnamese					Not Disclose				
If registered with CAQH, CAQH ID number:						Medicare/PTAN number:			



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Section 2: [Employer ID number/Tax information](#)

*denotes a required field

*Social Security number	
*Is your EIN/Tax ID number the same as your SSN?	Yes No (If no , enter Tax ID number below)
EIN/Tax number	
EIN/Tax Name as indicated on IRS document	
*Tax exempt	Yes No
Medicare / PTAN number	

If you are a practitioner joining a group, the group's fax 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.

Section 3: [Specialty](#)

*denotes a required field

*Specialty	
Residency completed (MD, DO, DPM, DMD/DDS)?	Yes No
If yes , residency completion date:	
*Board certified (MD, DO)	Yes No
*Board eligible (MD, DO)	Yes No
*Do you practice exclusively in a hospital setting? If yes , Section 1 of CAQH must be updated to reflect hospital based status (MD, DO)	Yes No



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Section 4: Requested networks

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 have countersigned 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.

BCBSM and BCN do not permit retroactive effective dates in their managed care networks.

Select networks you are applying to:

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



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Section 5: Address data

*denotes a required field

Primary office address (Must be an address where health care services are rendered and may be published in BCBSM/BCN provider directories)		
*Street address		
*City	*State	ZIP code
Primary telephone number must be a phone number patients can call to make an appointment		
*Primary telephone number Extension	Fax number	

Payment/Remit address		
Street Address		
City	State	Zip Code

Mailing address (if different from your primary address)		
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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Section 5: Address data (continued)

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			
Additional address - Accessibility							
*Handicap accessibility: Yes No				*Accessible by bus: Yes No			
Work email address				Preferred method of contact? Email US Mail			
*Primary address - Accessibility							
Office Hours	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Open Time							
Close Time							

Section 6: Services

Select the following Telehealth services you provide:

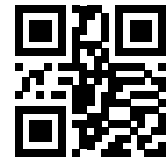
Telehealth Services	
Telehealth - Audio/Visual	Telehealth - Telephone Only

Behavioral Health Services

Select Age Ranges Treated:

0-12 (Child) 13-17 (Adolescent) 18-64 (Adult) 65+ (Geriatric) Other: _____

Check Counseling Services Provided	
Mental Health Outpatient Services	
Substance Use Outpatient Services	



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Do you offer Medication Assisted Treatment (MAT)	Yes	No
If yes, please select applicable programs below:		
Medication Assisted Treatment for Opioid Use - Suboxone/Buprenorphine	Add	Remove
Are you currently accepting new patients for Suboxone/Buprenorphine Medication Assisted Treatment?	Yes	No
If yes , would you like to be displayed in the directory for the above services?	Yes	No
Medication Assisted Treatment for Opioid Use – Vivitrol/Naltrexone	Add	Remove
Are you currently accepting new patients for Vivitrol/Naltrexone Medication Assisted Treatment?	Yes	No
If yes , would you like to be displayed in the directory for the above services?	Yes	No



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Section 6: Services *(continued)*

In an effort to assist in matching the patient need to available providers, please indicate your facility's special areas of interest below. Select no more than ten total treatment specialties and treatment modalities. 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 specialties below.**

By selecting the below specialties or modalities, you are attesting that you or your staff have received specialized education, training, and supervision in that specialty/modality.

Select Treatment Specialties	
ADD / ADHD	Add
Anxiety, Phobias and Related Disorders	Add
Autism	Add
Bereavement / Grief / Loss	Add
Disorders of Childhood & Adolescence	Add
Dissociative Disorders	Add
Eating and Feeding Disorders	Add
Gambling Disorder	Add
Gaming (compulsive)	Add
Gender / Transgender Identification	Add
Geriatric / Older Adult Disorders	Add
HIV / AIDS	Add
LGBTQ+	Add
Mood Disorders	Add
Obsessive Compulsive and Related Disorders	Add
Opioid Use Disorders	Add
Pain Management	Add
Personality Disorders	Add
Pregnancy Challenges	Add
Psychotic Disorder	Add
PTSD / Trauma Disorders	Add
Selective Mutism	Add
Sexual Addiction	Add
Sexual Dysfunction	Add
Substance Use Disorders	Add
Traumatic Brain Injury	Add

Appropriate Treatment Modalities	
ADOS Testing (trained / qualified) for Autism	Add
Adult Intensive Services (AIS)	Add
Applied Behavior Analysis (ABA) for Autism	Add
Bariatric Evaluations	Add
Brief Dynamic Therapy	Add
Children's Intensive Services (CIS)	Add
Cognitive Behavioral Therapy (CBT)	Add
Dialectical Behavioral Therapy (DBT)	Add
Electroconvulsive Therapy (ECT)	Add
Exposure Response Prevention (ERP) Therapy	Add
Eye Movement Desensitization Reprocessing (EMDR)	Add
Interpersonal Therapy	Add
Medication Assisted Treatment (MAT) for Opioid Use – Suboxone/Buprenorphine	Add
Medication Assisted Treatment (MAT) for Opioid Use – Vivitrol/Naltrexone	Add
NAVIGATE	Add
Neurofeedback (for ADHD only)	Add
Neuropsychological Testing	Add
Psychological Testing	Add
Transcranial Magnetic Stimulation (TMS)	Add



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Section 7: Additional Practice Locations

(Must be an address where health care services are rendered and may be published in BCBSM/BCN provider directories)

#1	Street Address						
	City			State		ZIP Code	
	Telephone Number			Fax Number			
Additional address - Accessibility							
*Handicap accessibility: Yes No				*Accessible by bus: Yes No			
Office Hours	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Open Time							
Close Time							

#2	Street Address						
	City			State		ZIP Code	
	Telephone Number			Fax Number			
Additional address - Accessibility							
*Handicap accessibility: Yes No				*Accessible by bus: Yes No			
Office Hours	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Open Time							
Close Time							



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Section 8: [Application Signature](#)

Have you ever been convicted of, plead guilty to, or nolo contendere to any felony?

No Yes (Insert nature of offenses)

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In the past ten years have you been convicted of, pled guilty to, or pled nolo contendere to any misdemeanor (excluding minor traffic violations) or been found liable or responsible for any civil offense that is reasonably related to your qualifications, competence, function, or duties as a medical professional, or for fraud, an act of violence, child abuse or a sexual offense or sexual misconduct?

No Yes (Insert nature of offenses)

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In the past ten years, has any professional corporation, partnership, limited liability company or any other such entity in which you own an equity interest (directly or indirectly) and/or serve any management or leadership function (including, but not limited to, acting as a manager, board member, director, or executive) been convicted of, pled guilty to, or pled nolo contendere to any misdemeanor or been found liable or responsible for any civil or criminal offense?

No Yes (Insert nature of offenses)

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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