Instructions for fax cover sheet

We cannot accept handwritten forms. To ensure forms are processed timely, please adhere to the following instructions:

1. Do not hand write anywhere on the forms, otherwise processing will be delayed.
2. 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/YY)
        - Type 1 National Provider Identifier
        - State license number
        - When adding an individual to an existing group be sure to include your group's Type 2 National Provider Identifier and a group change form

    - For allied providers
        - From (Insert name of contact person)
        - Date (MM/DD/YY)
        - Type 2 NPI National Provider Identifier
        - Tax identification number

    - For group practices
        - From (Insert name of contact person)
        - Date (MM/DD/YY)
        - Type 2 National Provider Identifier
        - Tax identification number

Instructions for form 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.)

3. You can also mail the completed forms and documentation to:

Provider Enrollment
Blue Cross Blue Shield of Michigan
P.O. Box 217, Southfield, MI 48034

Questions? Call 1-800-822-2761

FAX OR MAIL COVER SHEET FOR DOCUMENTS

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

Fax To: 866-900-0250 Provider Enrollment

From:

Date:

Mail to: Provider Enrollment
Blue Cross Blue Shield of Michigan
P.O. Box 217
Southfield, MI 48034

Form Number: 10575

Type 1 NPI:

Type 2 NPI:

State License Number:

Blue Cross Blue Shield Blue Care Network of Michigan

Nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association

New Mental Health Practitioner Enrollment

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

Please complete this form if you are a psychiatrist, fully licensed psychologist, clinical licensed master's social worker or clinical nurse specialist 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://upd.caqh.org/oas/ 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 licensed master's social worker ☐ clinical nurse specialist ☐ certified nurse practitioner
*County where your primary address is located	
*Degree	
*Date of birth	
Gender	☐ Male ☐ Female
Preferred salutation	☐ Dr. ☐ Ms. ☐ Mrs. ☐ Mr. ☐ Miss
If registered with CAQH, CAQH ID number	

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New Mental Health Practitioner Enrollment

State license number	Type 1 National Provider Identifier	Type 2 National Provider Identifier

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 ID Number	
EIN/Tax name as indicated on IRS document	
*Tax exempt	☐ Yes ☐ No

If you would like to bill with your Type 2 NPI representing your incorporated individual business, you must **also** complete a New Group Enrollment form to register this entity as a group.

Section 3: Specialty

*denotes a required field

*Specialty	
*Board certified	☐ Yes ☐ No

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:** If applying to participate with Traditional, BCBSM Mental Health and Substance Abuse Managed Care Network, Medicare Advantage PPO, BCN Commercial, BCN Advantage HMO SM, please return an Individual Signature Document for each network.

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

Select networks you are applying to:

BCBSM Networks	Requested Networks
Traditional	☐ Participating ☐ Nonparticipating Requested effective date:

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

Section 4: Requested networks – continued

Select networks you are applying to:

BCBSM Networks	**Requested Networks**
TRUST PPO	☐
Medicare Advantage PPO	☐
BCBSM Mental Health and Substance Abuse Managed Care Network	☐
BCN networks	**Requested networks** **Note: Clinical Nurse Specialists are not eligible for BCN networks.**
BCN Commercial	☐
BCN Advantage HMO SM	☐

If you do not want to enroll with BCBSM/BCN, but wish to register your information for Medicare Plus Blue PFFS SM **Only** check here ☐

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	Fax number	

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New Mental Health Practitioner Enrollment

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

Section 5: Address data - continued

Payment address (If different from your primary address)		
Street address		
City	State	ZIP code

Mailing address (if different from your primary address)		
Street address		
City	State	ZIP code

Primary address - Accessibility

*Handicap accessibility ☐ Yes ☐ No *Accessible by train ☐ Yes ☐ No

*Accessible by bus ☐ Yes ☐ No

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	Fax number
E-mail	Preferred method of contact? ☐ E-mail ☐ U.S. Mail Click here for explanation

Primary Address – Office Hours

Office Hours	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Open time							
Close time							

*Do you provide 24/7 coverage at this location? ☐ Yes ☐ No

Blue Cross Blue Shield Blue Care Network of Michigan

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New Mental Health Practitioner Enrollment

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

Section 5: Address data - continued

Levels of care/Services:	**Age categories:**
☐ Mental health outpatient services	☐ **Child** (0-12) ☐ **Adolescent** (13-17) ☐ **Adult** (18-64) ☐ **Geriatric** (65+)
☐ Substance abuse outpatient services	☐ **Adolescent** (13-17) ☐ **Adult** (18-64) ☐ **Geriatric** (65+)
☐ Drug ambulatory outpatient detox	☐ **Adolescent** (13-17) ☐ **Adult** (18-64) ☐ **Geriatric** (65+)
☐ Alcohol ambulatory outpatient detox	☐ **Adolescent** (13-17) ☐ **Adult** (18-64) ☐ **Geriatric** (65+)
Psychiatric specialty services:	
☐ In-home mental health	
☐ Psychiatric RN	
☐ Social work	

Therapeutic modality:			
Modality	Number of cases treated in last 12 months or list certification as indicated*	Modality	Number of cases treated in last 12 months or list certification as indicated*
☐ Brief dynamic therapy		☐ Group therapy	
☐ Cognitive behavioral therapy*		☐ Interpersonal therapy	

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

Section 5: Address data - continued

Therapeutic modality:			
Modality	Number of cases treated in last 12 months or list certification as indicated*	Modality	Number of cases treated in last 12 months or list certification as indicated*
☐ Dialectical behavioral therapy*		☐ Neuropsychological testing	
☐ Eclectic therapy		☐ Psychological testing	
☐ Family therapy			

Special areas of interest: To help us with patient referrals, please check off special areas of interest if you have particular expertise:

Special areas of interest			
Area of interest	If adding: number of cases treated in last 12 months	Area of interest	If adding: number of cases treated in last 12 months
☐ Anger management		☐ Anxiety/Panic disorders	
☐ Attention deficit Hyperactivity disorders		☐ Autism	
☐ Bariatric		☐ Chronic medical illness	
☐ Dementia/Alzheimer		☐ Depression	
☐ Disability		☐ Disassociative disorders	
☐ Disorders of childhood & adolescence		☐ Eating disorders	
☐ Gambling addiction		☐ Gay/Lesbian	

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

Section 5: Address data - continued

Special areas of interest			
Area of interest	If adding: number of cases treated in last 12 months	Area of interest	If adding: number of cases treated in last 12 months
☐ Gender Identification/ Transgender		☐ Grief/Bereavement	
☐ HIV/AIDS		☐ Obsessive-Compulsive disorders	
☐ Pain management		☐ Personality disorders	
☐ Phobias		☐ Post traumatic stress disorder	
☐ Schizophrenia/Psychosis		☐ Sexual abuse	
☐ Sexual dysfunction		☐ Traumatic brain injury	
☐ Women's issues			

All provider services:

☐ E-prescribing functionality Click here for explanation	☐ In-home visits

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

Section 6: 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	

Handicap accessibility ☐ Yes ☐ No Accessible by train ☐ Yes ☐ No

Accessible by bus ☐ Yes ☐ No

Office hours	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Open time							
Close time							

Do you provide 24/7 coverage at this location? ☐ Yes ☐ No

#2 Street address			
City		State	ZIP code
Telephone number		Fax number	

Handicap accessibility ☐ Yes ☐ No Accessible by train ☐ Yes ☐ No

Accessible by bus ☐ Yes ☐ No

Office hours	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Open time							
Close time							

Do you provide 24/7 coverage at this location? ☐ Yes ☐ No

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

Section 7: Provider secured services – web-DENIS

*denotes a required field

Doing business electronically saves your office time and money. We encourage you to sign up for Provider Secured Services, a free service for BCBSM and BCN participating providers that allows you to view patient eligibility, track claims, and much more online. Begin the process by completing the information in the section below:

Authorized Web Access Administrator

Provide the name and contact information of the person who is the authorized Web Access Administrator with delegated authority to manage all access to protected health information and group practitioner records using provider secured (web) self services.

*Name (Type or print)	*Title
*Telephone	*E-mail
*Does the individual named above currently use Provider Secured Services (web-DENIS)?	☐ Yes ☐ No **Click here for explanation**
If yes, indicate the individual's Provider Secured Services user ID.	User ID

Provider Secured Services Access If No, complete section Provider Secured Services Access.

Complete the section below for individuals that do not have an existing Provider Secured Services (web-DENIS) login ID. Only check-off the minimum necessary features for each user listed below.

*Name (full legal name of each user) *Telephone Number & E-mail	Eligibility Coverage	Claims Tracking	BCN PCP Claims Summary	Provider Claim Correction	Internet Claims Tool
1. *Name	☐	☐	☐	☐	☐
*Telephone Number	E-mail				
2. *Name	☐	☐	☐	☐	☐
*Telephone Number	E-mail				
3. *Name	☐	☐	☐	☐	☐
*Telephone Number	E-mail				
4. *Name	☐	☐	☐	☐	☐
*Telephone Number	E-mail				
5. *Name	☐	☐	☐	☐	☐
*Telephone Number	E-mail				

The authorized signer agrees that he/she has the company's designated authority to request and maintain minimum necessary Web access and is responsible for complying with all terms and conditions contained within the Provider Secured Service Use and Protection Agreement.

*Authorized Signature	*Date

Complete the Provider Secured Service Use and Protection Agreement and return with this application. If you have additional user names, please list and attach separately with access features denoted.

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New Mental Health Practitioner Enrollment

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Section 8: Internet claims tool

If you currently submit paper claims and would like to submit electronic claims through this tool, complete Section 7 above, and the information below.

Check the payers and remittance report you would like to sign up for							
Blue Cross Blue Shield of Michigan	Blue Care Network	BCBSM Medicare Advantage	Medicare DME	Medicare	Medicaid	Commercial	Electronic Remittance
☐	☐	☐	☐	☐	☐	☐	☐
Internet browser and version							
Hardware and operating system							

SECTION 9: 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.

*Print or type name	*Practitioner signature/Title	*Date

When Completed