Provider Enrollment Form

Please fax the completed form to (716) 887-2056, along with your Certificate of Liability Insurance.

BlueCross BlueShield of Western New York

Thank you for your interest in becoming a participating provider with BlueCross BlueShield of Western New York.

Please complete all information requested on this enrollment form. The information provided must match your CAQH application; incomplete forms or forms that do not match CAQH will be returned. The CAQH application must be completed and re-attested with authorization to BlueCross BlueShield to access the application. The credentialing process will not begin until we have a completed application.

Provider name: _____ PCP: Yes ☐ No ☐

Provider type (MD, DO, DPM, NP, PA, etc.): _____

Enrolling as an Independent Nurse Practitioner? Yes ☐ No ☐

If yes, please attach a completed Independent Nurse Practitioner NP-CR Collaborative Relationships Attestation Form

Specialty: _____ Is the provider board certified? Yes ☐ No ☐

NYS license #: _____ DOB: _____

Sponsoring physician name for NP, PA, CRNA, CNM: _____

CAQH #: _____ Tax ID #: _____

Individual NPI #: _____

Group name: _____ Group NPI #: _____

Enrolled with Medicare? Yes ☐ No ☐ If yes, individual Medicare number*: _____

***If you are enrolling with Medicare and are indicating yes in the box above, please make sure your CAQH application is updated with the corresponding Medicare number. If you would like to enroll in our Medicare Advantage network post enrollment, please contact your Provider Practice Consultant.**

Has provider opted out of Medicare? Yes ☐ No ☐

Par with Medicaid? Yes ☐ No ☐ If yes, Medicaid number*: _____

***At the time of enrollment in order to be placed in a Medicaid Line of Business the practitioner must present a Medicaid acceptance letter with Medicaid Management Information Systems (MMIS) Provider ID listed.**

Please list all practice locations below

Address type:	Practice name:			
(Check all that apply)	**Physical practice address as listed on CAQH**			
☐ Primary office	**Street address** (street level **only**):			STE:
☐ Additional office	City:	County:	State:	Zip:
☐ Clinic	Office phone: **MUST MATCH CAQH**		Office fax:	
☐ Hospital	Email:			
☐ Urgent care	Can members schedule appointments: ☐ Yes ☐ No		Oncall/Covering only: ☐ Yes ☐ No	
☐ Inpatient				
☐ Skilled nursing				

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Address type:	Practice name:					
(Check all that apply)	**Physical practice address as listed on CAQH**					
☐ Primary office	**Street address** (street level **only**):					STE:
☐ Additional office	City:		County:		State:	Zip:
☐ Clinic	Office phone: **MUST MATCH CAQH**			Office fax:		
☐ Hospital	Email:					
☐ Urgent care	Can members schedule appointments: ☐ Yes ☐ No		Oncall/Covering only: ☐ Yes ☐ No			
☐ Inpatient						
☐ Skilled nursing						

Address type:	Practice name:					
(Check all that apply)	**Physical practice address as listed on CAQH**					
☐ Primary office	**Street address** (street level **only**):					STE:
☐ Additional office	City:		County:		State:	Zip:
☐ Clinic	Office phone: **MUST MATCH CAQH**			Office fax:		
☐ Hospital	Email:					
☐ Urgent care	Can members schedule appointments: ☐ Yes ☐ No		Oncall/Covering only: ☐ Yes ☐ No			
☐ Inpatient						
☐ Skilled nursing						

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(Check all that apply)	**Physical practice address as listed on CAQH**					
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☐ Additional office	City:		County:		State:	Zip:
☐ Clinic	Office phone: **MUST MATCH CAQH**			Office fax:		
☐ Hospital	Email:					
☐ Urgent care	Can members schedule appointments: ☐ Yes ☐ No		Oncall/Covering only: ☐ Yes ☐ No			
☐ Inpatient						
☐ Skilled nursing						

*Attach additional locations

Credentialing contact name: ______________________________ Date: __________

Credentialing phone: ____________________ Email: ______________________________

Office manager name: ______________________________ Date: __________

Office manager phone: ____________________ Email: ______________________________

Provider direct Email: ______________________________

PRACTITIONER DISCLOSURE OF OWNERSHIP AND CONTROL

Completion is required by 42 CFR Part 455.104
{**If additional space is needed, copy form; all entries must be on the form**}

SECTION 1:

Disclosing Entity/Applicant (Individual named on page 1 of CAQH Application)

Name	NPI	
Home Address (street)	City & State	Zip Code (9 digit)
SSN	Date of Birth (MM/DD/YYYY)	

Ownership in Applicant Include familial relationship to the Applicant and other Owners (spouse, parent, child, sibling), if any. The address for corporate entities must include every business address.

Name of Individual or Entity		% of Ownership	Entity/Group NPI
Business Address (Home address if individual)		City & State	Zip Code (9 digit)
SSN (if individual)	FEIN (if entity)	Date of Birth (if individual) (MM/DD/YYYY)	Familial Relationship (if individual, if any)

SECTION 2:

Ownership in Other Disclosing Entities (ODE) (Complete if any identified in Section 1 has an ownership or controls interest in ODE).

Name (from section 1)	Name of ODE	NPI
Name (from section 1)	Name of ODE	NPI

SECTION 3:

Ownership in Subcontractors If the Applicant has an ownership or controls interest of 5% or more in a subcontractor **and** an Owner of the Applicant also has an ownership or controls interest in the subcontractor, complete the boxes below. If those identified in this Section have a familial relationship with a person with ownership or interest in one of these subcontractors, complete Section 4.

Owner's Name (from section 1)	Subcontractor's Name	Tax ID
Owner's Name (from section 1)	Subcontractor's Name	Tax ID

SECTION 4:

Familial Relationship in Subcontractors Complete if those identified in Section 3 have a familial relationship* with a person with ownership or control interest in one of the subcontractors identified in Section 3.
*parent, child, sibling, spouse

Owner's Name (from section 1)	Subcontractor's Name	Name & Familial Relationship
Owner's Name (from section 1)	Subcontractor's Name	Name & Familial Relationship

SECTION 5:

Managing Employees (e.g. office manager, administrator, director or other individuals who exercise operational or managerial control over the day to day operations of the provider). Include familial relationship to the Applicant (e.g. spouse, parent, child, sibling) if any. If additional space is needed, copy form.

Name	Title	
Home Address (street)	City & State	Zip Code (9 digit)
SSN	Date of Birth (MM/DD/YYYY)	Familial Relationship (if applicable)

Name	Title	
Home Address (street)	City & State	Zip Code (9 digit)
SSN	Date of Birth (MM/DD/YYYY)	Familial Relationship (if applicable)

Name	Title	
Home Address (street)	City & State	Zip Code (9 digit)
SSN	Date of Birth (MM/DD/YYYY)	Familial Relationship (if applicable)

SECTION 6:

Respond to these questions on behalf of:
1. The Applicant
2. All individuals and entities identified in Sections 1 & 5
3. Any entity in which the Applicant has a 5% or more ownership

1. Have any of the individuals/entities (1, 2, and 3) been terminated, denied enrollment, suspended, restricted by Agreement or otherwise sanctioned by the Medicaid Program in New York or any other state, Medicare, or other governmental or private medical insurance program?

   ☐ Yes ☐ No

2. Have any of the individual/entities (1, 2, and 3) ever been convicted of a crime related to the furnishing of, or billing for, medical care or supplies, or which is considered an offense involving theft or fraud or an offense against public administration or against public health and morals in any state?

   ☐ Yes ☐ No

3. Have any of the individuals/entities (1, 2, and 3) ever had their business or professional license or certification of an entity for which they had an ownership interest over 5% ever been revoked, suspended, surrendered, or in any way restricted by probation or agreement by any licensing authority in any state?

☐ Yes ☐ No

4. Are there currently any pending proceedings that could result in the above stated sanctions for the individuals/entities (1, 2, or 3)?

☐ Yes ☐ No

NOTE: If you answered "Yes" to any of the questions above, you must complete and submit the "Disclosure History Form" available at **bcbswny.com/provider**

5. Has there been a change of ownership or control within the last 12 months to any of the entities (1, 2, and 3)?

☐ Yes ☐ No

If "Yes", provide:
NPI
Date of Ownership Change (MM/DD/YYYY)

6. Do you anticipate a change of ownership within the next 12 months to any of the above entities (1, 2, and 3)?

☐ Yes ☐ No

If "Yes", when do you anticipate the ownership change will occur:

SIGNATURE AND AFFIRMATION

By signing this Disclosure form, the Applicant/Provider understands and agrees to the following:

- As a Provider you agree to comply with the rules, regulations and official directives of the Department of Health (DOH) including, but not limited to Part 504 of 18NYCRR, which can be found at the Department of Health's website, **health.ny.gov**
- In addition, pursuant to 42 CFR, Part 455.105, you agree to disclose the following regarding business transactions within the next 35 days upon request of the DOH or the Secretary of Health and Human Services.
  (1) Information about the ownership of any subcontractor with whom the provider has had business transactions totaling more than $25,000 during the 12-month period ending on the date of the request, and
  (2) Any significant business transactions between the provider and any wholly owned supplier, or between the provider and any subcontractor during the five-year period ending on the date of the request.
- As a Provider you agree to abide by all applicable federal and state laws as well as the rules and regulations of other New York state agencies
- As a Provider you agree to notify us immediately of any changes in practice including impending ownership changes.
- As a Provider you maintain a policy that outlines your process to monitor staff and employees against the stated exclusion list (List of Excluded Individuals and Entities and the Restricted, Terminated, or Excluded Individuals or Entities List) and report any exclusions to BlueCross BlueShield of Western New York on a monthly basis.

WHOEVER KNOWINGLY AND WILLFULLY MAKES OR CAUSES TO BE MADE A FALSE STATEMENT OR REPRESENTATION ON THIS STATEMENT MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS. IN ADDITION, KNOWINGLY AND WILLFULLY FAILING TO FULLY AND ACCURATELY DISCLOSE THE INFORMATION REQUESTED MAY RESULT IN DENIAL OF A REQUEST TO PARTICIPATE OR WHERE THE ENTITY ALREADY PARTICIPATES, A TERMINATION OF ITS AGREEMENT OR CONTRACT WITH THE STATE AGENCY OR SECRETARY, AS APPROPRIATE.

Print or Type the Name of Person Signing Below

Title

If Applicant / Provider is a legal entity other than a person, the person signing this Disclosure document on behalf of the Applicant / Provider warrants that he/she has legal authority to bind the Applicant / Provider. (NOTE: for Changes of Ownership, New Owner or Representative must sign).

Signature of Provider or Authorized Representative

Date (MM/DD/YYYY)

Name and Telephone Number of Person who Prepared Disclosure Form

NEW YORK STATE DEPARTMENT OF HEALTH
Office of Health Insurance Programs

Participating Provider Owner/Manager Disclosure Certification

Instructions

In accordance with the New York State Department of Health Standard Clauses for Managed Care Provider/IPA Contracts section B(9)(l), providers are required to have an officer, director or partner of the Provider execute the following certification within 5 days of executing a new agreement with a Medicaid Managed Care Organization (MCO). The MCO must retain this document with the applicable contract for validation during operational surveys. Individual Practitioners must complete Sections A, D and E.

Questions regarding this certification can be directed to BMCCSProgInt@health.ny.gov.

Certification Category (Choose one): ☐ Participating Provider Certification ☐ Subcontractor Certification

Section A Participating Provider Information

Participating Provider Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

FEIN or SSN: _____

Section B Officer, Director or Partner Information (if different from above)

First Name: _____ Last Name: _____ Middle Initial: _____ Suffix: _____

Title: _____

Phone Number: _____ Email Address: _____

Section C Managed Care Organization(s)

Name of the Managed Care Organization the Participating Provider has an agreement with to provide services to Medicaid beneficiaries:

MCO Name: _____

Anticipated Contract Term: _____ To: _____

Date of Execution: _____

Section D Questions

In order to complete the Participating Provider Owner/Manager Disclosure Certification form, you must certify each of the following statements:

The person signing below, declares, affirms and certifies (hereinafter certification) that the information entered as part of this form is true and that:

1. That the Participating Provider named on this form is subject to the statutes, rules, regulations, and applicable Medicaid Updates of the Medicaid program and of the New York State Department of Health related to the furnishing of care, services or supplies provided directly by, or under the supervision of, or ordered, referred or prescribed by the Participating Provider. This includes 18 NYCRR § 515.2, except to the extent that any reference in the regulation establishing rates, fees and claiming instructions will refer to the rates, fees and claiming instructions set by the Managed Care Organization(s) named on this form. ☐ I Certify
2. That all care, services or medical supplies for which the provider submits claims for payment have been provided. ☐ I Certify
3. That payment requests are submitted in accordance with applicable law. ☐ I Certify

Section E Certification

IMPORTANT: Making a false statement in this certification may subject you to criminal prosecution for a misdemeanor or felony under the New York State Penal Law.

The person signing below, declares, affirms and certifies (hereinafter certification) that the information entered as part of this form is true and that:

1. he/she is the certifying official/provider whose name and contact information appears above;
2. the certifying official/provider has undertaken due diligence and conducted all reasonable inquiry prior to making any of the statements in this certification and has sufficient knowledge to complete this form; and
3. the certifying official/provider acknowledges that this certification is being made in order to comply with the requirements outlined in the questions answered above.

Signature _____ Date _____