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

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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) ☐ 3-17 (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)

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)

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)

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