



Blue Cross and Blue Shield of New Mexico

FOR OFFICE USE ONLY
PROV ID:
PFIN ID: NM
NPI:

APPLICATION FOR FACILITY/AGENCY/VENDOR

Please print:

Facility/Agency/Vendor Name:

Specialty:

NPI (National Provider Identifier) #:

Federal Tax I.D. Number:

Are you currently a Medicare provider in New Mexico? Yes No

Current Medicare PTAN #:

Physical Location #1 - Name:

Street: Effective Date of this Address: / /

City: State: Zip:

Phone No: Fax No: E-mail Address:

Business Office Manager:

Note: If more than one location, please attach additional sheet and use the back of this application.

Billing Address:

Street/P.O. Box:

City: State: Zip:

Phone No: Fax No: Contact Person:

Mailing Address:

Street/P.O. Box:

City: State: Zip:

Phone No: Fax No: Contact Person:

List contractual affiliations:

Services Provided (check all that apply): Acute Care Hospital Specialty Hospital DME Home Health: Skilled Nursing Nurses Aide PT OT Speech

Home IV Therapy (including nursing, supplies, equipment, and pharmaceuticals): Hospice

Please describe your current service area:

Participation will require the provider to submit claims directly to Blue Cross and Blue Shield of New Mexico.  
What system of filing will you use?

CMS-1500 \_\_\_ UB 04 \_\_\_ Other (explain) \_\_\_\_\_

Does your facility have wheelchair access? \_\_\_\_\_

Has your company ever been listed on an OIG or other government sanction list? Yes \_\_\_ No \_\_\_

**Please provide the following information:**

1. Copy of current State license
2. Proof of Professional Liability Insurance and amounts
3. Service or program description (if applicable)
4. Copy of most recent Accreditation report or a copy of the Department of Health or CMS site visit (if not nationally accredited)
5. Copy of Medicare Participation Certificate (if Medicare pending, please send copy as soon as you receive it)
6. Copy of Quality Assurance Program & annual evaluation of plan
7. Copy of licensure and/or certification of all applicable employees
8. Completed W-9
9. Copy of the Letter 147C sent to you by the IRS
10. Copy of most recent CMS or Department of Health survey
11. Copy of letter or e-mail from the Enumerator verifying NPI assignment

**Additional Requirements for Ambulatory Surgical Center:**

1. Must be approved for reimbursement as an Ambulatory Surgery Center (ASC) under Medicare
2. Must have a written referral agreement with at least one acute care hospital

**All of the above facilities must meet BCBSNM "needs" test.**

**Please attach additional pages as necessary.**

**NOTE: If any information on this application is not complete, the contracting process will NOT continue until all requested information is received.**

*I hereby represent and warrant that all information contained in this application is true, correct, and complete in all aspects. I understand and agree that any misrepresentation in this application by omission or affirmative statement shall be grounds for termination.*

Print Name: \_\_\_\_\_ Title: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Application does not guarantee participation.**

**Mail your application to: BCBSNM, ATTN: Network Services (HQ- 3), P.O. Box 27630, Albuquerque, NM 87125-7630**