



Blue Cross and Blue Shield of New Mexico

FOR OFFICE USE ONLY
PROV ID:
PFIN ID: NM
Type 1 NPI:
Type 2 NPI:

APPLICATION FOR PROVIDER PARTICIPATION

Please print:

Physician's/Provider's Last Name, First Name, MI, Degree/Title

Applying as: Primary Care Physician, Specialist Physician, Other Ancillary Provider

Please indicate if you are an existing Provider: Yes No

NPI (National Provider Identifier) #:
SS#: Date of Birth: Sex: M F
DEA#: Expiration Date:

Are you enrolled in Medicare? Yes No If so, do you accept Medicare assignment? Yes No
Medicare PTAN #: Effective Date:
NM State License #: Effective Date:

Under what specialty would you like to be listed in directory?
Primary Specialty BOARD CERTIFIED? BOARD ELIGIBLE?
Secondary Specialty

Have you ever been convicted of a felony or fraud?
Has your license to practice medicine in any jurisdiction ever been suspended or revoked?
Does your physical/mental health limit you in any way from performing your duties as a physician?
While practicing medicine, have you ever been impaired by alcohol or other chemical substances?
Have your privileges at any hospital ever been restricted, revoked, or not renewed?
Have you ever been listed on an OIG or other government sanction list?
If you answered yes to any of the above questions, please include a detailed letter of explanation.

List Covering Physicians using complete name (First, Middle, Last) and the provider specialty:
NOTE: Must be same specialty as applicant in order to do call coverage and must be participating with BCBSNM.

Any limitations to practice (e.g., gyn only, only up to 18 years of age, females only):
Any limitations to weekly practice hours (please advise if office hours per week are less than 4 days/week):

Do you or your staff speak other languages? Yes No
If yes, which languages:

List hospitals with whom active staff privileges are currently held, and estimated percent of practice in each hospital.

Please complete all fields; if not applicable, please indicate "NA."

Are you associated with a: Group _____ Clinic _____ IPA _____ PHO _____ Solo _____
Legal Entity Name: _____ Effective Date: ____ / ____ / ____
Payment to be made to: _____ Tax ID #: _____ Phone #: _____
Type 2 NPI #: _____ Does your facility have wheelchair access? Yes No

NOTE: Federal Tax Identification Number (TIN) or Employer Identification Number (EIN) must be reported exactly as the IRS has it recorded. This information can be found on the Letter 147C sent to you by the IRS.

Primary Location Address: _____ **General Appointment Scheduling Phone Number (if applicable):** _____

Name: _____ **Business Office Manager:** _____
Street: _____ **Effective Date:** ____ / ____ / ____
City: _____ **State:** _____ **Zip Code:** _____
Phone Number: _____ **Fax No:** _____ **E-mail Address:** _____

Physical Location #2 – Name: _____ **Business Office Manager:** _____
Street: _____ **Effective Date:** ____ / ____ / ____
City: _____ **State:** _____ **Zip Code:** _____
Phone Number: _____ **Fax No:** _____ **E-mail Address:** _____

Please attach any additional addresses on a separate sheet.

Mailing Address:
Street/P.O. Box: _____
City: _____ **State:** _____ **Zip Code:** _____
Phone No: _____ **Fax No:** _____ **Business Office Manager:** _____

Billing Address:
Street/P.O. Box: _____
City: _____ **State:** _____ **Zip Code:** _____
Phone Number: _____ **Fax No:** _____ **Business Office Manager:** _____

APPLICANTS MUST SUBMIT THE FOLLOWING WITH THIS APPLICATION:

1. Completed W-9
2. Copy of the Letter 147C sent to you by the IRS
3. Copy of letter or e-mail from the Enumerator verifying NPI assignment
4. Copy of current New Mexico medical license with expiration date
5. Copy of current DEA certificate
6. Copy of Medicare Participation Certificate (if Medicare pending, please send copy as soon as you receive it)
7. Copy of current malpractice insurance policy with expiration date

NOTE: Current amounts of coverage must meet our minimum requirements

8. Current Curriculum Vitae which must include medical school internships, residencies, fellowships, etc.

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: Blue Cross and Blue Shield of New Mexico, ATTN: Network Services (HQ-3), P.O. Box 27630, Albuquerque, NM 87125-7630