



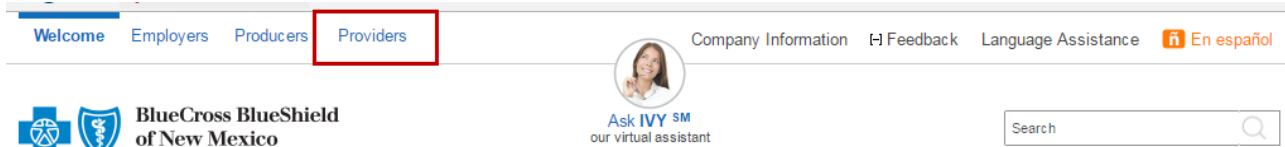
**BlueCross BlueShield
of New Mexico**

Provider Onboarding Form

User Guide


Access the Provider Onboarding Online Form

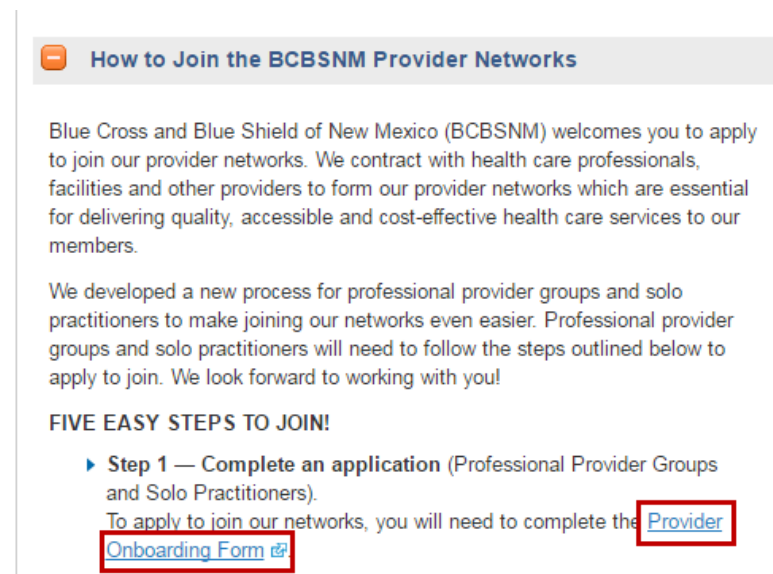
1. For best results use the **Google Chrome** browser.
2. To access the form from the Blue Cross Blue Shield of New Mexico website, click the **Providers** tab.



3. On the **Providers** Tab, select the **Network Participation** tab and then select **How to Join** from the list of options.



4. Click the  icon to expand the **How to Join the BCBSNM Provider Networks** section and click the hyperlink to the Provider Onboarding Form. The Provider Enrollment form opens.



If you have any questions or need assistance as you are completing the form, click the **Contact Us** link at the bottom of any page.

[HOME](#) | [LEGAL AND PRIVACY](#) | [NON-DISCRIMINATION NOTICE](#) | [CONTACT US](#)

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1 - Select Participation

This section allows you to enter submitter information and to select the type of participation you prefer.

Note: Be sure you have all the required and applicable information ready before you begin completing the form. You will not be able to save the form and return to complete it later. The form will time out after 30 minutes of inactivity.

Submitter Information

1. Enter the name and contact information of the person submitting the form.

All email correspondence related to this case will go to this contact.

2. Select whether to **participate in network** or **participate out-of-network**.

Submitter Information

Required *

First Name *

ex. John

Middle Initial

Optional

Last Name *

ex. Smith

Suffix

Optional

Email Address *

ex. yourname@email.com

Telephone Number *

ex. (234) 567-8901

Job Title/ Position *

ex. Supervisor

Please select from one of the following options: *

☐

I wish to participate in-network.

☐

I wish to participate out-of-network.

3. Click the **Continue to Enter Your Information** button.

Continue to Enter Your Information

2 – Enter Your Information

The selections on this page will depend on whether you are participating in network or out-of-network. Refer to the appropriate steps below based on your selection and provider type.

In Network – Solo Provider

1. Select the **Contract as Solo Provider** button.

Note: If you need to change demographics under your current contract, please use the Web Demographic Change Form at:
<https://hcscproviderintake.secure.force.com/NMDemographUpdate>

2. Select the **Network(s)** from the list.
3. Click **Continue to Enrollment**.

Required *

Complete the form for: *



Contract as Solo Provider



Add New Group/ Clinic



Add Providers to an Existing
Contracted Group/ Clinic

Network *
Select

Back

Continue to Enrollment

In Network – Add New Group/Clinic

1. Select the **Add New Group/Clinic** button. If you intend to contract as a Group/Clinic.

Note: If you need to change demographics under your current contract, please use the Web Demographic Change Form at <https://hcscproviderintake.secure.force.com/NMDemographUpdate>.

2. Select the **Network(s)** from the list.
3. Click the **Download Provider Roster Template** button. The Excel file downloads to your computer.

Please use only this template to complete your roster.

4. Complete the Roster Template and save it. You will upload it in the Attachments section of the form.
5. Click **Continue to Enrollment**.

Required *

Complete the form for: *

☐ Contract as Solo Provider
☒ Add New Group/ Clinic
☐ Add Providers to an Existing Contracted Group/ Clinic

Network *

Provider Roster Instructions

Please complete the Provider Roster and upload in the Attachments section (Optional for New Group/Clinic and Required for Existing Group/Clinic). Download and fill out the template now, or at a later date. Enrollment is pending upon submitting a completed roster. If uploading a completed roster at a later date, choose "Add Providers to an Existing Group/Clinic" to upload in the Attachments section.

In Network – Add Providers to Existing Contracted Group/Clinic

1. Select the **Add Providers to an Existing Contracted Group/Clinic** button. If you are a currently contracted group and are adding additional providers to your contract.

Note: If you need to change demographics under your current contract, please use the Web Demographic Change Form at <https://hcscproviderintake.secure.force.com/NMDemographUpdate>.

2. Complete the required fields.
3. Click the **Download Provider Roster Template** button. The Excel file downloads to your computer.

Please use only this template to complete your roster.

4. Complete the Roster Template **with the names of the providers being newly added** and save it. You will upload it in the Attachments section of the form.

Please complete the Roster in its entirety as all information that is requested/required is needed for us to process your request. If the required information is not included, it will delay the processing of your request.

5. Click **Continue to Enrollment**.

Required *

Complete the form for: *

- ☐ Contract as Solo Provider
☐ Add New Group/ Clinic
☒ Add Providers to an Existing Contracted Group/ Clinic

Existing Group Practice Name *

Smith & Smith #1 Specialists

Existing Group Type 2 NPI (Organization) *

ex. 1234567890

Existing Group Tax Identification Number (TIN)/ Employer Identification Number (EIN) *

ex. 1234567890

Confirm Existing Group Tax Identification Number (TIN)/ Employer Identification Number (EIN) *

Re-type the Tax ID/EIN

Network *

Select

Provider Roster Instructions

Please complete the Provider Roster and upload in the Attachments section (Optional for New Group/Clinic and Required for Existing Group/Clinic). Download and fill out the template now, or at a later date. Enrollment is pending upon submitting a completed roster. If uploading a completed roster at a later date, choose "Add Providers to an Existing Group/Clinic" to upload in the Attachments section.



Download Provider Roster template

Back

Continue to Enrollment

A disclaimer appears reminding you that there are additional processes outside of the enrollment process that need to happen before you are accepted as a participating provider.

Disclaimer

Please note completing this application does NOT mean that you are a participating provider. If you are requesting to be contracted, please note that your claims may pay out of network for services rendered until your contracts have been accepted, the credentialing process has been completed, and you receive an effective date.

OK

Out of Network - Solo Provider

1. Select the **Bill as Solo Provider** button.
2. Click **Continue to Enrollment**.

Required *

Complete the form for: *

- ☒ Bill as Solo Provider
- ☐ Add New Group/ Clinic

Back

Continue to Enrollment

Out of Network – Add New Group/Clinic

1. Select the **Add New Group/Clinic** button.
2. Click the **Download Provider Roster Template** button. The Excel file downloads to your computer.

Please use only this template to complete your roster.
3. Complete the Roster Template and save it. You will upload it in the Attachments section of the form.
4. Click **Continue to Enrollment**.


Required *

Complete the form for: *

- ☐ Bill as Solo Provider
- ☒ Add New Group/ Clinic

Provider Roster Instructions

Please complete the Provider Roster and upload in the Attachments section (Optional for New Group/Clinic and Required for Existing Group/Clinic).
Download and fill out the template now, or at a later date. Enrollment is pending upon submitting a completed roster.
If uploading a completed roster at a later date, choose "Add Providers to an Existing Group/Clinic" to upload in the Attachments section.

 Download Provider Roster template

Back

Continue to Enrollment

3 – Enroll as a Provider

In this section you will provide important details about the solo provider or group/clinic and the services they will provide.

Practitioner Information (Solo Provider Only)

Enter information about the practitioner.

1. Indicate if the provider is currently in a **residency program**.

Note: A provider in a residency program can apply; however, they cannot join a network. If you select Yes, you receive an informational message.

2. At a minimum, complete all required (*) fields. However, if additional data is recommended be sure to enter it now to prevent a delay in the processing of your request.

Is the provider currently in a residency program? * ☐ Yes ☐ No

Primary Provider Type *

Select Provider Type

Primary Provider Specialty *

Select Specialty

☐ Board Certified

CAQH Number

ex. 1234567890

License Number *

ex. 1234567890

Tax Identification Number (TIN) *

ex. 1234567890

Confirm Tax Identification Number (TIN)*

Re-type the Tax Identification Number

Group Practice Information (Group/Clinic Provider Only)

Enter information about the group or clinic.

1. At a minimum, complete all required (*) fields. However, if additional data is recommended be sure to enter it now to prevent a delay in the processing of your request.

Group Practice Name *

Smith & Smith #1 Specialists

Group Practice Start Date *

MM/DD/YYYY

Type 2 NPI (Organization) *

ex. 1234567890

Tax Identification Number (TIN) *

ex. 1234567890

Edit

+ Add NPI

Confirm Tax Identification Number(TIN) *

Re-type the Tax Identification Number

Group Website URL *

ex. http://hcsc.com/who-we-are

☐ N/A

Personal Information (Solo Provider Only)

The section contains personal information about the provider.

1. Open the section by clicking the arrow in the title bar.

Personal Information



2. If the personal information is the same as the submitter information you just entered, check the **Same as Submitter** checkbox. The following information will default:
 - First Name
 - Middle Initial, if entered
 - Last Name
 - Suffix, if entered

3. If the information is not the same as the submitter information, complete all required (*) fields. However, if additional data is recommended be sure to enter it now to prevent a delay in the processing of your request.

Note: You can select multiple Titles.

4. Click the Continue to Enrollment button.

Required *

☐ Same as Submitter

First Name *

ex. John

Middle Initial

Optional

Last Name *

ex. Smith

Suffix

Optional

Title(s) *

Select

Date of Birth *

MM/DD/YYYY

Gender *

☐ Male ☐ Female


Back

Continue to Enrollment

Additional Personal & Practitioner Information (Solo Provider Only)

The section contains additional personal information about the individual.

- At a minimum, complete all required (*) fields. However, if additional data is recommended be sure to enter it now to prevent a delay in the processing of your request.

Note: Click the  for more information about the field.

Required *

Applying As * 

- ☐ Primary Care Physician/ Provider
- ☐ Specialty Care Physician/ Provider

Additional Provider Type/ Specialty/ Sub-Specialties

Provider Type



Medicare Number

ex: alphanumeric

Medicaid Number

ex. 9-12 numerical number

DEA Number

ex. 1-9 Alphanumeric number

Hospital Privileges

ex. 1234567890

[+ Add Hospital Privileges](#)

Ambulatory Surgery Center Privileges

ex. 1234567890

Additional Personal & Practitioner Information – Continued

6. At a minimum, complete all required (*) fields. However, if additional data is recommended be sure to enter it now to prevent a delay in the processing of your request.

Note: If the NPI number is invalid, you will receive a message. You will have to attach your NPI Enumerator Response in the Attachments section of this enrollment form.

If the NPI number is not recognized by nppes.com, the system will not allow you to submit the application.

Type 1 NPI (Individual) *

1234567890



The NPI provided is not Active on www.nppes.com. Please reach out to NPPES to correct the issue before re-applying. To continue please attach a copy of your NPI Enumerator Response in section 3H of this form.

Language(s) Spoken

Select

Cultural Competency Training Completed? *

☐ Yes ☐ No

Completion Date

MM/DD/YYYY

Type 1 NPI (Individual) *

ex. 1234567890

☐ NPI Not Required

Social Security Number

ex. 123456789

Confirm Social Security Number

Re-type the Social Security Number

Ethnicity



Practitioner Website URL *

ex. http://hcsc.com/who-we-are

☐ N/A

Additional Group Practitioner Information (Group/Clinic Provider Only)

The section contains additional information about the group or clinic.

1. Open the section by clicking the arrow in the title bar.

Additional Group Practitioner Information



- At a minimum, complete all required (*) fields. However, if additional data is recommended be sure to enter it now to prevent a delay in the processing of your request.

Primary Provider Type/ Specialty/ Sub-Specialties

Primary Group Type *

Select Provider Type

Primary Group Specialty *

Select Specialty

Additional Provider Type/ Specialty/ Sub-Specialties

Group Type

Office Physical Location

Enter information about the physical location(s) of the office(s).

- Open the section by clicking the arrow in the title bar.

Office Physical Location



- At a minimum, complete all required (*) fields. However, if additional data is recommended be sure to enter it now to prevent a delay in the processing of your request.

Note: You can enter multiple locations.

If you have multiple offices in one Street Address be sure to include the Suite Number for each.

Location Name

Optional

Office Contact Name *

ex. John Smith

Telephone Number *

ex. (234) 567-8901

Fax Number

Optional

Street Address/ Suite Number *

ex. Street Address, P.O. Box

City *

ex. Springfield

State *

Select State

Zipcode *

ex. 12345 or 123456789

Email Address *

ex. name@company.com

☐ N/A

Appointment Phone Number *

ex. (234) 567-8901

Start Date at This Location *

MM/DD/YYYY

Location Offers Language Line Services ?* ☐ Yes ☐ No

Office Physical Location – Continued

3. At a minimum, complete all required (*) fields. However, if additional data is recommended be sure to enter it now to prevent a delay in the processing of your request.

Note: You can add multiple Services and Back Up Providers per location.

Required for government business

Servicing Practice Locations (check all that apply)

- ☐ Patient's Home Visits Only
- ☐ Patient's Work Place Visits Only
- ☐ Hospice Visits Only
- ☐ Nursing Home Visits Only
- ☐ Skilled Nursing Facility Visits Only

Service(s) performed at this location

Optional

Supervising Physician

Optional

Remove

+ Add Service

Back Up Provider

Remove

+ Add Back Up Provider

- ☒ This is Primary Location for this Provider
- ☐ This location is accepting new patients

☐ Please exclude from Provider Directory

Tips for Hours of Operation

- Add Day function allows a maximum of 7 days.
- Add Time allows a maximum of 3 time sets.
- Each day can be used only once in a single time block.
- Times cannot overlap.

Hours of Operation*

☐ Open 24/7 ☐ Office is closed ☐ By appointment only

☐ Mon ☐ Tue ☐ Wed ☐ Thu ☐ Fri ☐ Sat ☐ Sun

Opening Time

Closing Time

hh ▾ 00 ▾ AM/PM ▾ hh ▾ 00 ▾ AM/PM ▾

Please Fill Form completely

+Add Time

+ Add Day

Office Physical Location – Continued

4. At a minimum, complete all required (*) fields. However, if additional data is recommended be sure to enter it now to prevent a delay in the processing of your request.

Americans with Disabilities Act (ADA)

Are the following standards in accordance with American with Disabilities Act? *

☐ Yes ☐ No

If yes, please check at least one:

- | | |
|--|---|
| <input type="checkbox"/> Site Accessible | <input type="checkbox"/> Exam Table |
| <input type="checkbox"/> Parking Accessibility | <input type="checkbox"/> Office Reception Area |
| <input type="checkbox"/> Exterior Building | <input type="checkbox"/> Close Proximity to Public Transportation |
| <input type="checkbox"/> Interior Building | <input type="checkbox"/> Restroom |
| <input type="checkbox"/> Exam Room | <input type="checkbox"/> Scale |

Treating Categories

Does the provider treat the following? *

Please check at least one:

- | | |
|---|--|
| <input type="checkbox"/> Homebound | <input type="checkbox"/> Co-Occurring Disorders |
| <input type="checkbox"/> Homeless | <input type="checkbox"/> HIV/ AIDS |
| <input type="checkbox"/> Blindness or Visually Impaired | <input type="checkbox"/> Physical Disabilities |
| <input type="checkbox"/> Chronic Illness | <input type="checkbox"/> Deafness or Hard of Hearing |
| <input type="checkbox"/> Serious Mental Illness | |

Office Physical Location – Continued

- At a minimum, complete all required (*) fields. However, if additional data is recommended be sure to enter it now to prevent a delay in the processing of your request.

Associations

Are you associated with:

If selected, all fields for each Association are required.

☐ IPA (Independent Physician Association)

Name

Site Number

ex. A12

Tax ID

ex. 1234567890

Confirm Tax ID

Re-type the Tax ID

☐ PHO (Physician Hospital Organization)

Name

Site Number

ex. A12

Tax ID

ex. 1234567890

Confirm Tax ID

Re-type the Tax ID

☐ Health System

Name

☐ Federally Qualified Health Center (FQHC)

Name

Site Number

ex. A12

Tax ID

ex. 1234567890

Confirm Tax ID

Re-type the Tax ID

Office Physical Location – Continued

6. At a minimum, complete all required (*) fields. However, if additional data is recommended be sure to enter it now to prevent a delay in the processing of your request.

☐ Community Mental Health Center (CMHC)

Name	Site Number	Tax ID
	ex. A12	ex. 1234567890

Confirm Tax ID
 Re-type the Tax ID

☐ Rural Health Clinic (RHC)

☐ Indian Health Services Facility

Name	Name

☐ Planned Parenthood

☐ Core Service Agency (CSA)

Name	Name


7. Click **Save**.


Note: It is important that you do this after creating each location. You will not be able to proceed with the enrollment process until the location is saved.


Save

8. Once you save the location, a **Card View** is created.

9. Review the information.

Note: The  indicates that this location is the Primary Location.

10. If you need to edit the information, click . Don't forget to save your changes.





Address

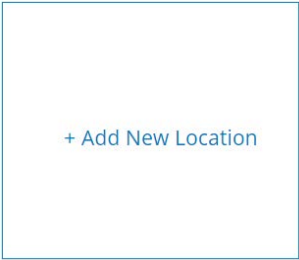



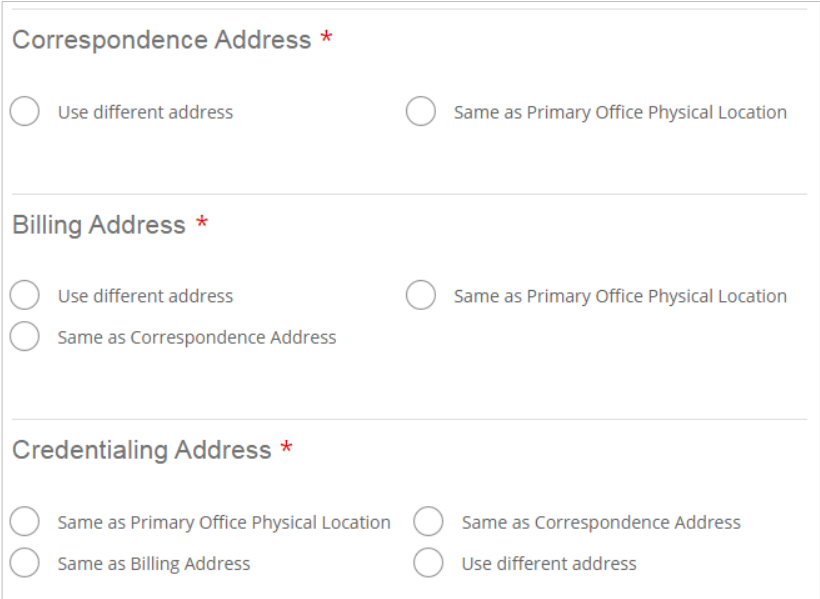
123 Main St Suite 10...

Albuquerque, NM 87101

Phone

5555555555

<p>11. If you need to add additional locations, click the Add New Location button.</p> <p>12. Complete the applicable information and click Save.</p>	
<p>Cancel button cancels your changes and returns you to the Card View.</p>	
<p>Delete button deletes the location.</p>	
<h3>Additional Addresses & Contact Information</h3> <p>Enter any additional addresses and contact information for the locations.</p>	
<p>1. Open the section by clicking the arrow in the title bar.</p>	
<p>You can enter different addresses for each of the address requirements or use the same address(es).</p> <p>2. Designate which address to use by selecting the appropriate option for each address type.</p> <p>3. If you chose to use a different address, you are prompted to enter it.</p>	

Additional Addresses and Contact Information – Continued

4. Enter the information for the Administrative Contact.

Administrative Contact ***Name ***

ex. John Smith

Job Title/Position *

ex. Supervisor

Telephone Number *

ex. (234) 567-8901

Fax Number

Optional

Email Address *

ex. name@company.com

☐ N/A**Comments**

Optional

Practice Information

This section contains information specific to the services the practice offers.

1. Open the section by clicking the arrow in the title bar.

Practice Information

2. At a minimum, complete all required (*) fields. However, if additional data is recommended be sure to enter it now to prevent a delay in the processing of your request.

TelemedicineDo you render Telemedicine Services? * ☐ Yes ☐ No**Scheduling Telephone Number**

ex. (234) 567-8901

☐ Same Phone Number as Primary Office Physical Location**Lab Services**Do you render Laboratory Services? * ☐ Yes ☐ No**CLIA Number**

ex. 12D4567890

Describe testing methodology

ex. Phlebotomy

Questionnaire

1. Open the section by clicking the arrow in the title bar.

Questionnaire



2. At a minimum, complete all required (*) fields. However, if additional data is recommended be sure to enter it now to prevent a delay in the processing of your request.

Required *

Please provide a detailed explanation, when answering "yes" to questions 2-8. When providing a detailed explanation to more than one "yes answer", please annotate the question number in front of your explanation.

1. Have you ever been a BCBSNM participating provider before? * ☐ Yes ☐ No
2. Have you ever been convicted of a felony or fraud? * ☐ Yes ☐ No
3. Has your license to practice medicine in any jurisdiction ever been suspended or revoked? * ☐ Yes ☐ No
4. Does your physical/mental health limit you in any way from performing your duties as a physician? * ☐ Yes ☐ No
5. While practicing medicine, have you ever been impaired by alcohol or other chemical substances? * ☐ Yes ☐ No
6. Have your privileges at any hospital ever been restricted, revoked, or not renewed? * ☐ Yes ☐ No
7. Have you ever been listed on an OIG or other government sanction list? * ☐ Yes ☐ No
8. Have you ever been debarred by Medicare/Medicaid? * ☐ Yes ☐ No

Explanation

Required if answered "yes" above

New Solo Provider Questionnaire

Required *

If you select "Yes" to any questions, an explanation is required below. Please include any previous Tax ID and NPI's used as a participating provider.

1. Have you ever been a BCBSNM participating provider before? * ☐ Yes ☐ No

Explanation

Required if answered "yes" above

New Group Provider Questionnaire

Attachments

In this section you will attach all the supporting documentation needed to complete your enrollment.

1. Open the section by clicking the arrow in the title bar.

Attachments



2. Select the **document type** from the list. The list contains all the required documents for your enrollment.

Required Documents:

The document types are not all required. We require a W-9 or IRS 147C for Solo and new Group requests. A Provider Roster is required when Adding a Provider to Existing Group/Clinic. The other types are recommended, but not required.

3. Click the **Upload Document** button.
4. Locate the file on your hard drive and upload.

Note: Be sure you are attaching the correct document to the document type.

5. Repeat steps 2-4 for each document.

Attachment Tips

- Only attach the documents requested in the list.
- Size cannot exceed 5MB.
- File names cannot exceed 140 characters.
- File types accepted: .bmp, .doc, .docx, .gif, .jpeg, .jpg, .pdf, .png.

Select Document Type:

Provider NPI Number
 Provider License Number
 CAQH Proof of Completion
 Proof of Medicaid Number
 Hospital Coverage Letter
 IRS 147C
 Disclosure of Ownership & Control Interest form
 Supervising Physician NPI Number
 W-9
 Cultural Competency Certificate
 Other

Solo Provider Document List

Select Document Type:

Provider Roster
 Provider NPI Number
 Disclosure of Ownership & Control Interest form
 IRS 147C
 W-9

Group/Clinic Provider Document List



Select Document Type:

Provider Roster
 Disclosure of Ownership & Control Interest form
 Provider NPI Number
 IRS 147C
 W-9

Add Provider to Existing Group/Clinic



Upload Document

<p>6. If you uploaded a document in error, click Remove to delete it.</p>	<div> -Attachment & upload #test@ chars.docx 206 KB <div>Remove</div> </div>
<h3>Comments</h3> <p>This section allows you to enter comments.</p>	
<p>1. Open the section by clicking the arrow in the title bar.</p>	<div>Comments </div>
<p>2. Type any comments, up to 2000 characters.</p>	<div>Optional</div>
<h3>Attestation</h3> <p>This section serves as your confirmation that all information entered is accurate and complete.</p>	
<p>1. Open the section by clicking the arrow in the title bar.</p>	<div>Attestation </div>
<p>2. At a minimum, complete all required (*) fields. However, if additional data is recommended be sure to enter it now to prevent a delay in the processing of your request.</p>	<div> I certify that the information submitted within this form is accurate and complete. <div> <div> Authorized Name * ex. John Smith </div> <div> Title * ex. Administrator </div> </div> <div> <div> Tax Identification Number * ex. 1234567890 </div> <div> Today's Date 01/27/2019 </div> </div> <div> Confirm Tax Identification Number * Re-type the Tax Identification Number </div> </div>
<p>3. Click the Continue to Review Information button to generate the enrollment form for your review.</p>	<div>Continue to Review Information</div>

4 - Review and Submit

This section provides a summary of your enrollment form for your review.

Review all of your entries and if you find any areas you need to edit, click the **Edit** button to the right of that section.

[Edit](#)

If you want to abandon this enrollment and start over, click the **Start Over** button. You will lose all the data you have previously entered. You will receive a confirmation message asking if you are sure you want to do this.

[Start Over](#)

When you are sure all data is complete and correct, click Submit Enrollment.

[Submit Enrollment](#)

5 - View Summary

Once you have submitted your enrollment, you will receive a summary page that shows the data that you entered and submitted. The Application ID is listed in the View Summary header. Make a note of this Application ID in case you need to contact BCBS with questions.

View Summary

Thank you for completing the BCBSNM enrollment. We will notify you once your application has been processed. If you requested to be contracted, please note that your claims may pay out of network for services rendered until your contracts have been accepted, the credentialing process has been completed, and you receive an effective date.

Application ID: 16917

If you have questions about your enrollment, contact the BCBS team using the phone number listed.

Contact Us

For status or if you have questions regarding your submission please call:
[1-800-567-8540](tel:1-800-567-8540)

If you want to print the summary, click the **Print Friendly Version**.

You can then print the summary or save it as a PDF.

[Print Friendly Version](#)

Email Confirmation

An email confirmation will be sent from BCBS to the contact listed on the Submitter Information page. The case number is listed in the email.

