BlueCross BlueShield of New Mexico

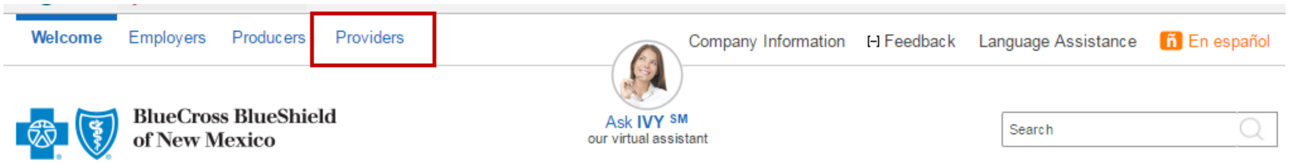
Provider Onboarding Form

User Guide

Access the Provider Onboarding Online Form

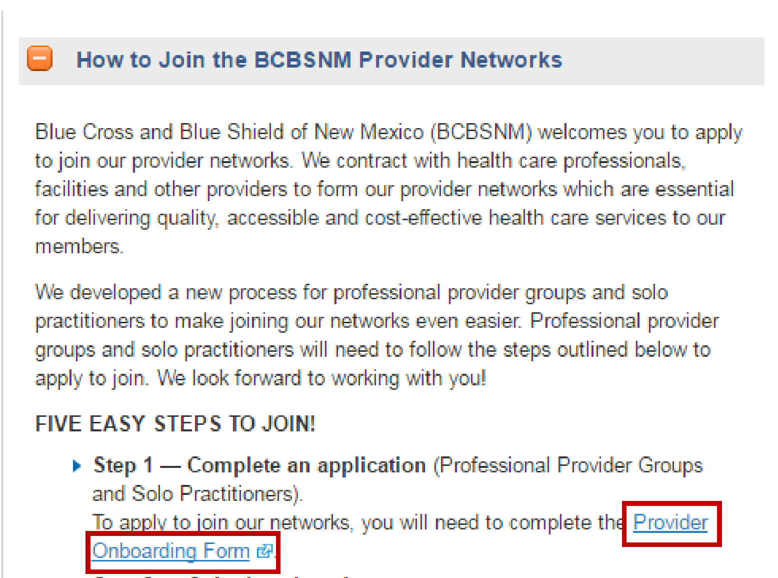
1. For best results use the **Google Chrome** browser.

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.

1 - Select Participation

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

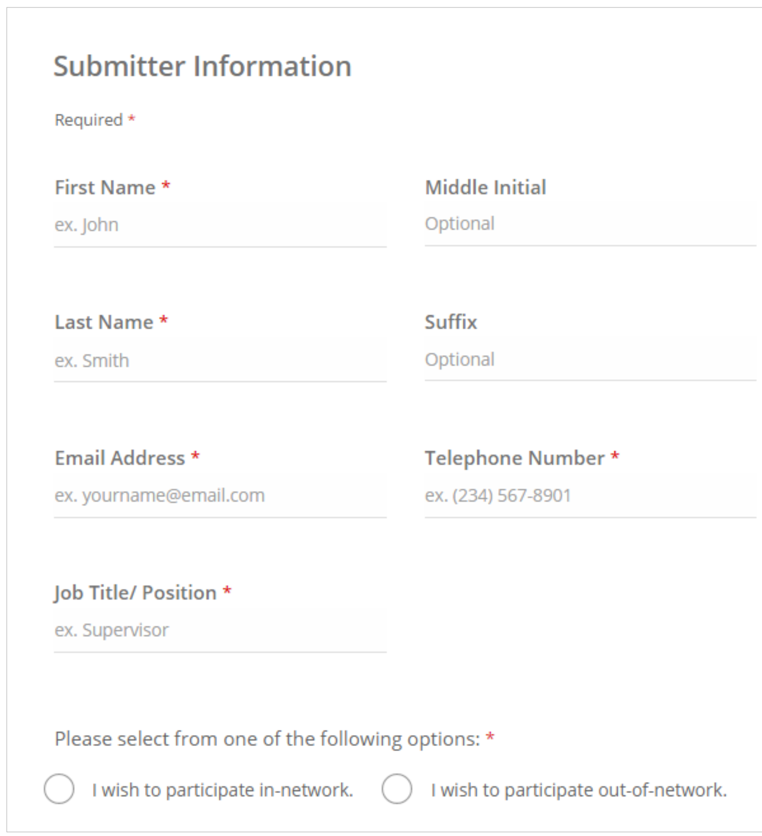
Note: Be sure you have all the required and applicable information ready before you begin completing the form. You will not be able to save the form and return to complete it later. The form will time out after 30 minutes of inactivity.

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**.



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

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.

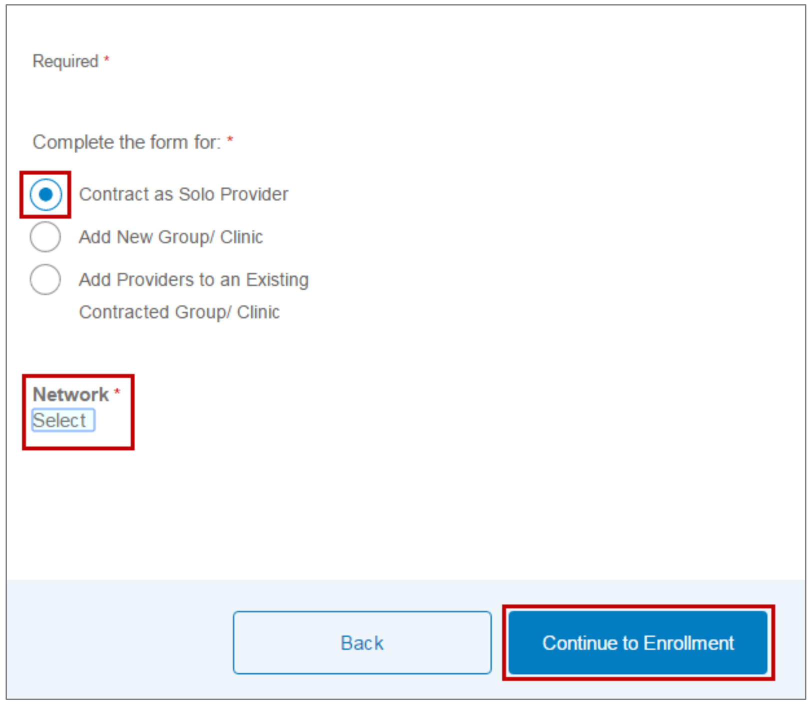
In Network – Solo Provider

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**.



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.

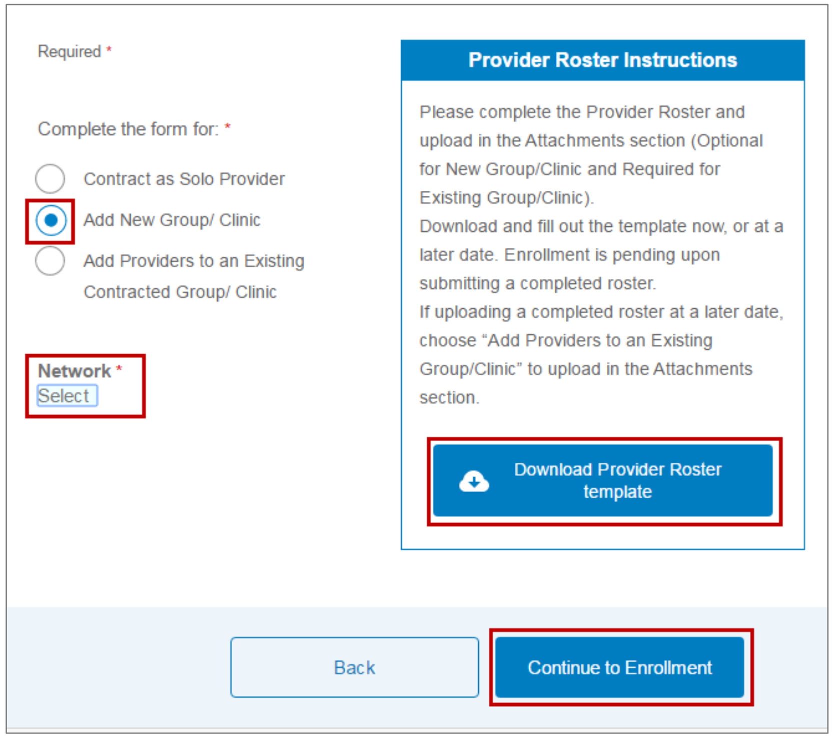
2. Select the **Network(s)** from the list.

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**.



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.

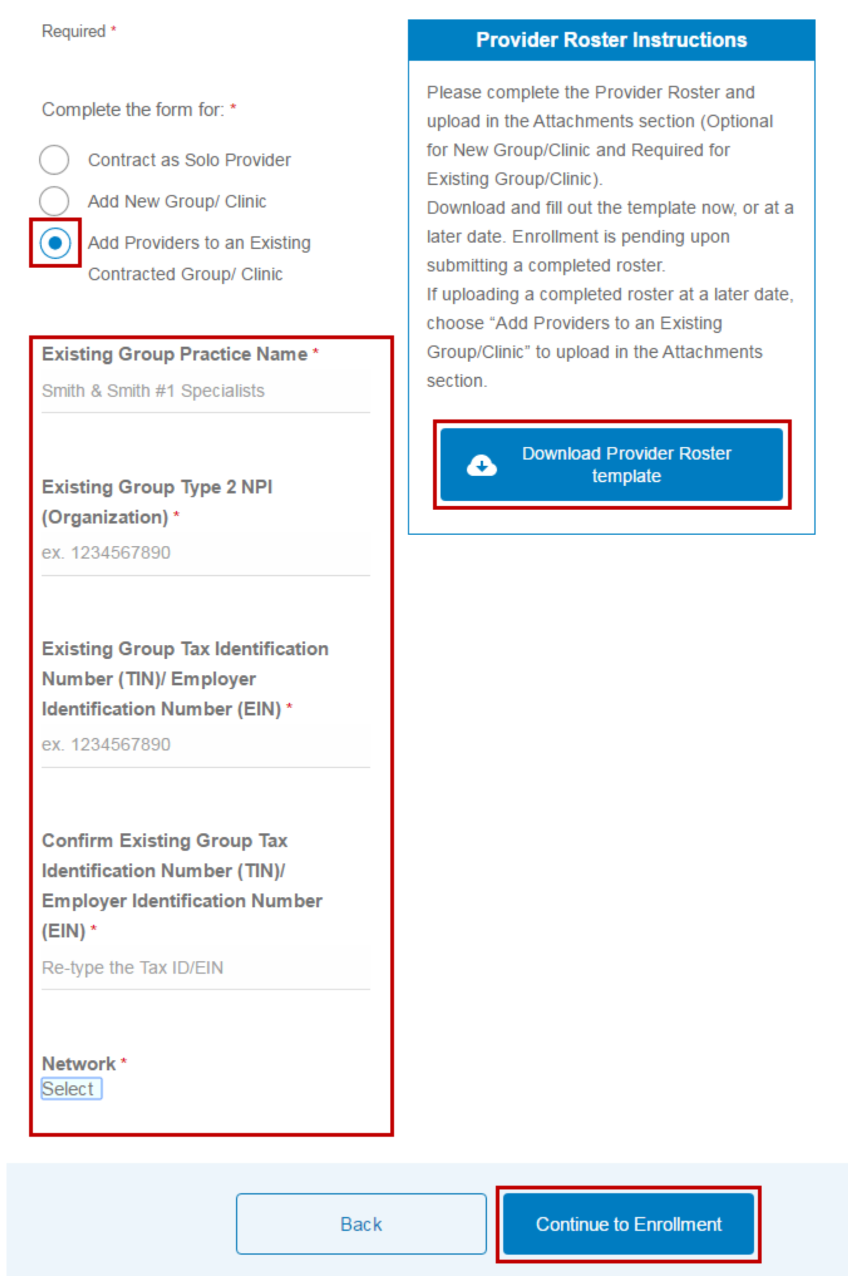
2. Complete the required fields.
3. Click the **Download Provider Roster Template** button. The Excel file downloads to your computer.

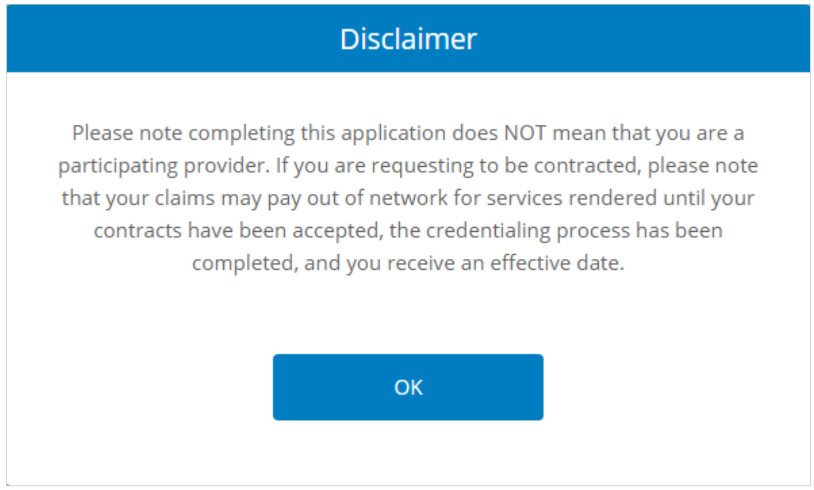
   Please use only this template to complete your roster.

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.

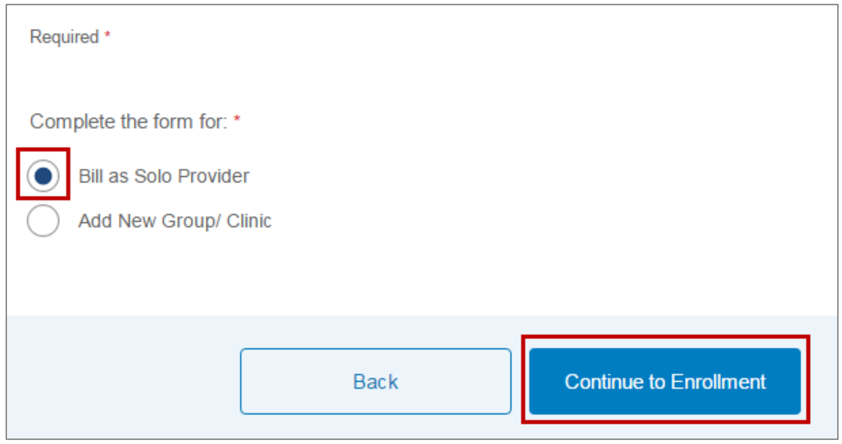
5. Click **Continue to Enrollment**.



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.	

Out of Network - Solo Provider

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

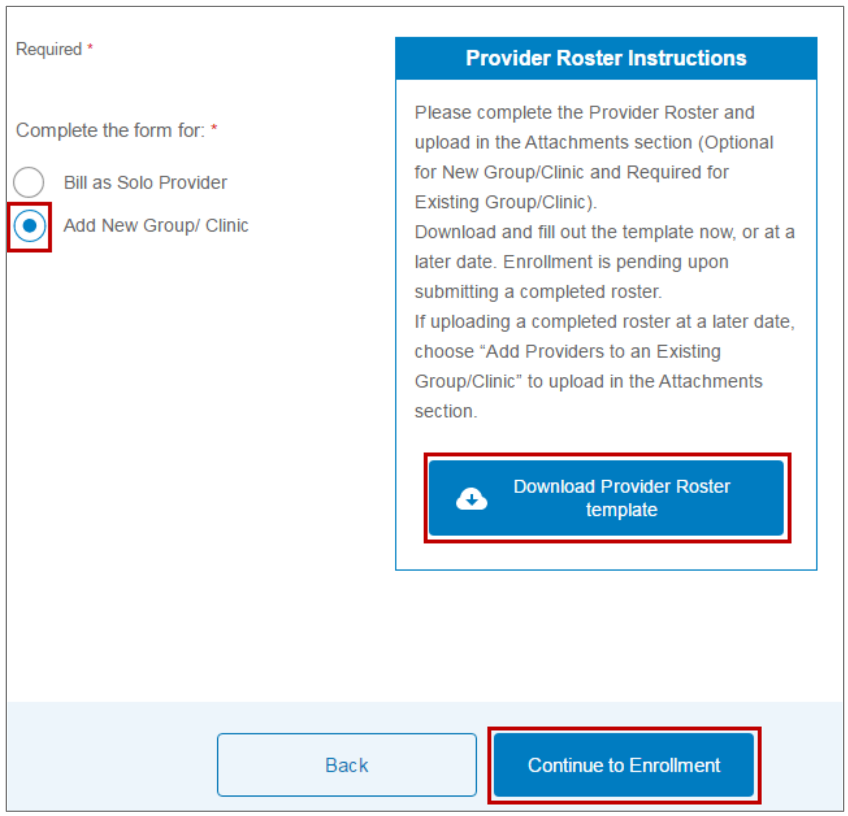


Out of Network – Add New Group/Clinic

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**.



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.

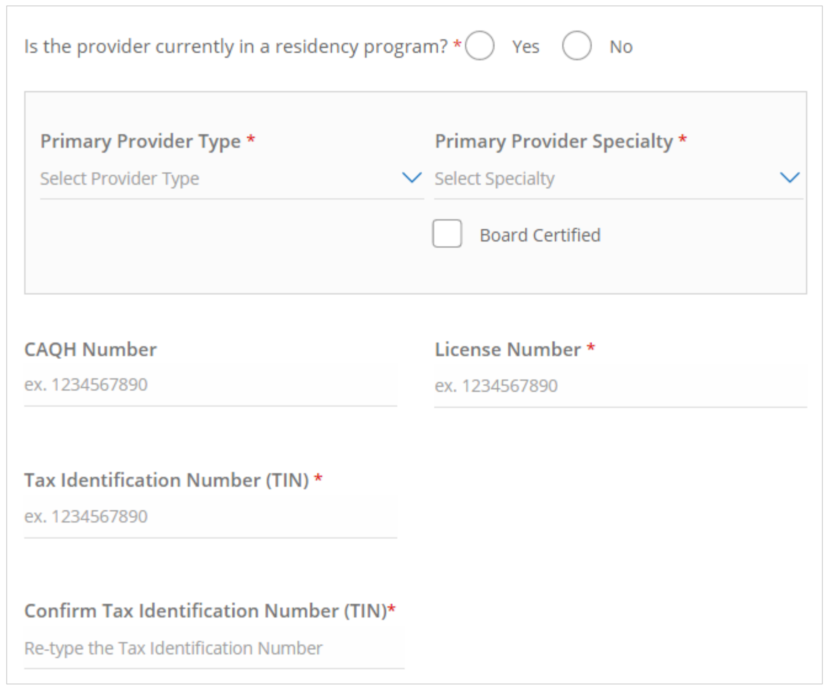
Practitioner Information (Solo Provider Only)

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.

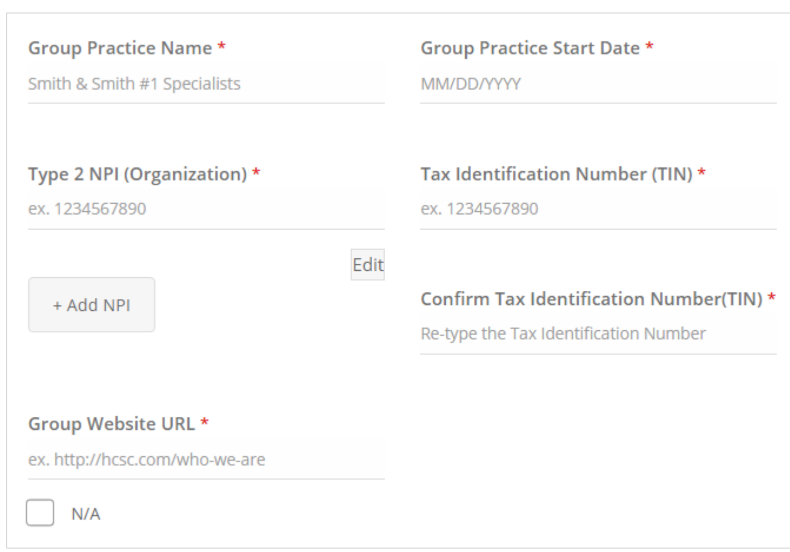
2. At a minimum, complete all required (*) fields. However, if additional data is recommended be sure to enter it now to prevent a delay in the processing of your request.



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.



Personal Information (Solo Provider Only)

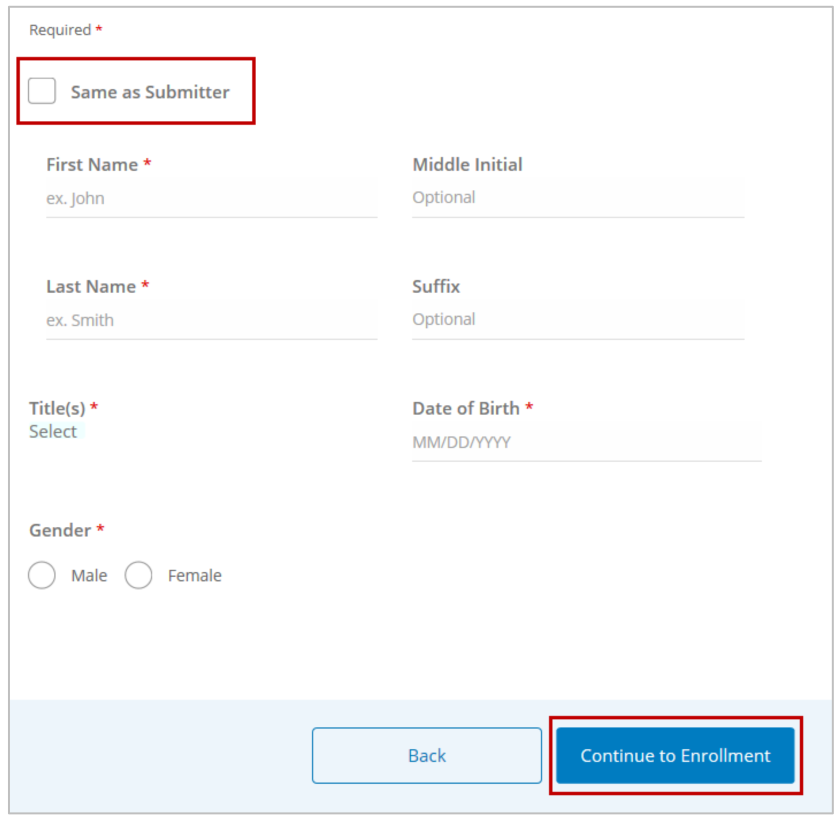
The section contains personal information about the provider.

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

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.

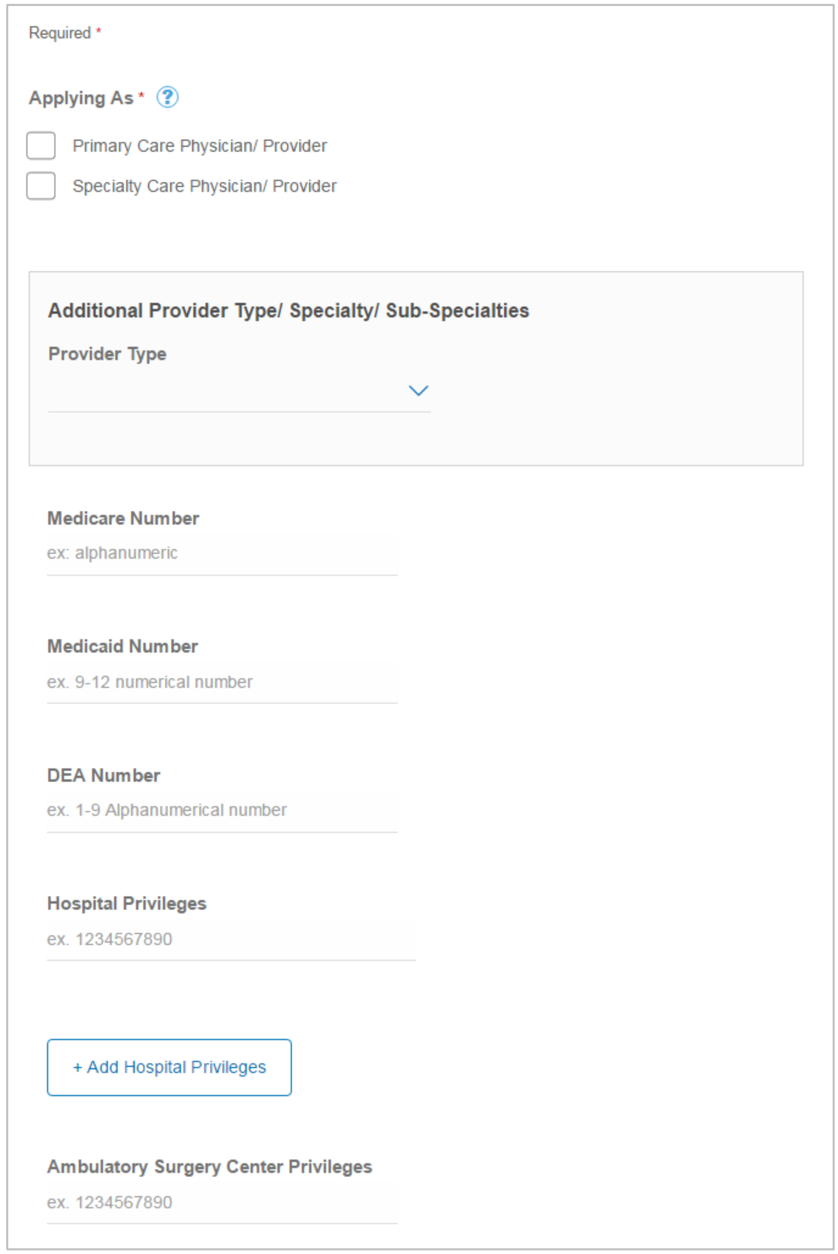


Additional Personal & Practitioner Information (Solo Provider Only)

The section contains additional personal information about the individual.

5. 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 Alphanumerical number

Hospital Privileges

ex. 1234567890

+ Add Hospital Privileges

Ambulatory Surgery Center Privileges

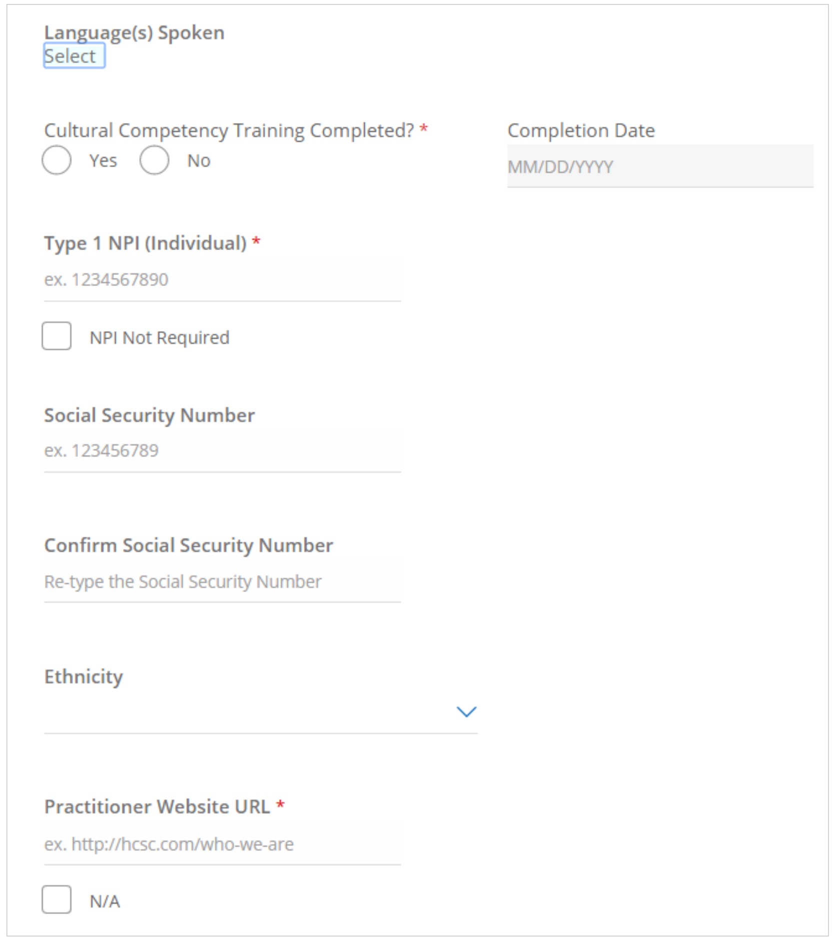
ex. 1234567890

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.

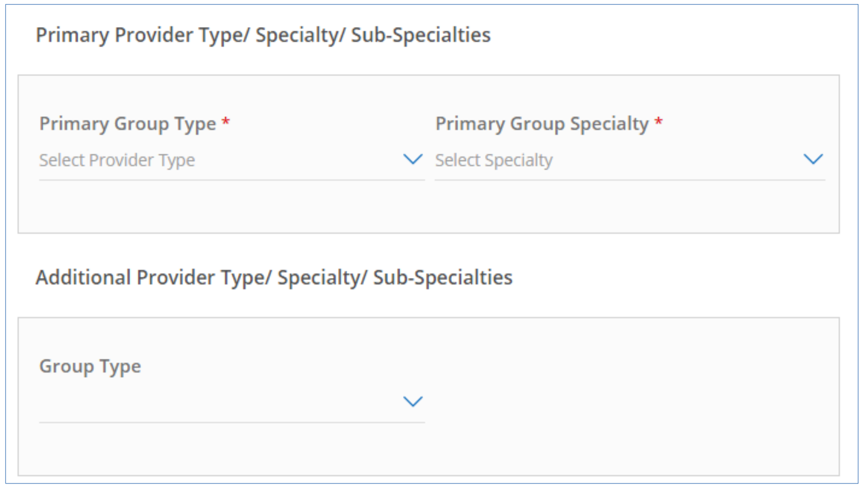


Additional Group Practitioner Information (Group/Clinic Provider Only)

The section contains additional information about the group or clinic.

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

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.



Office Physical Location

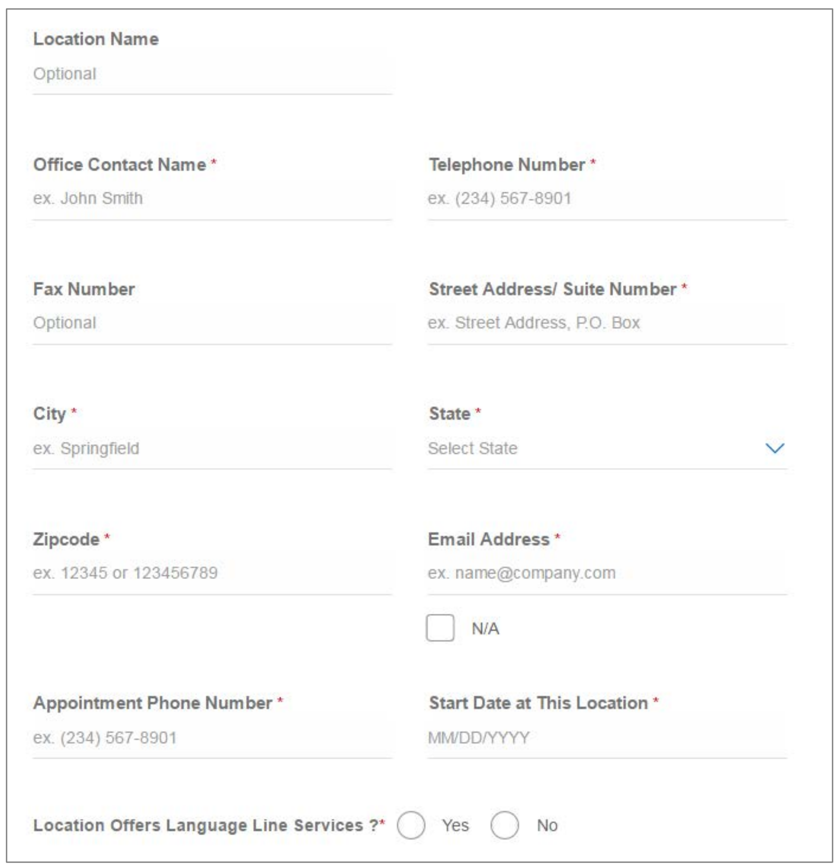
Enter information about the physical location(s) of the office(s).

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

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.

Note: You can enter multiple locations.

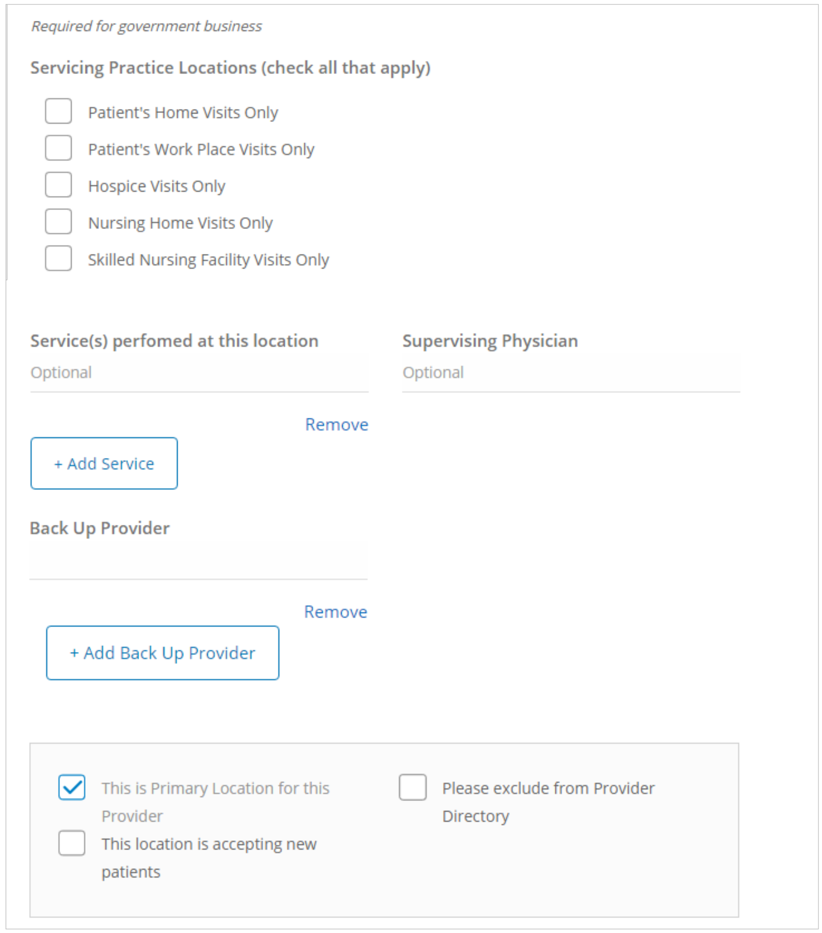
If you have multiple offices in one Street Address be sure to include the Suite Number for each.



Office Physical Location – Continued

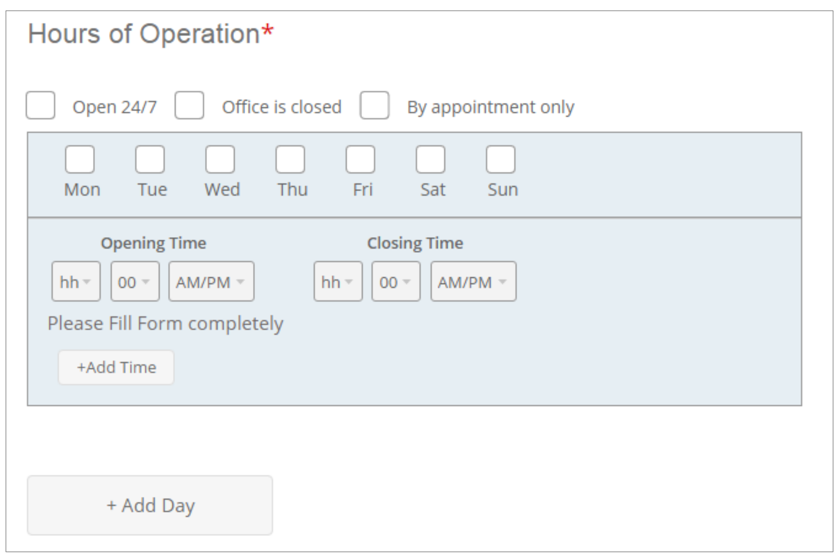
3. At a minimum, complete all required (*) fields. However, if additional data is recommended be sure to enter it now to prevent a delay in the processing of your request.

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



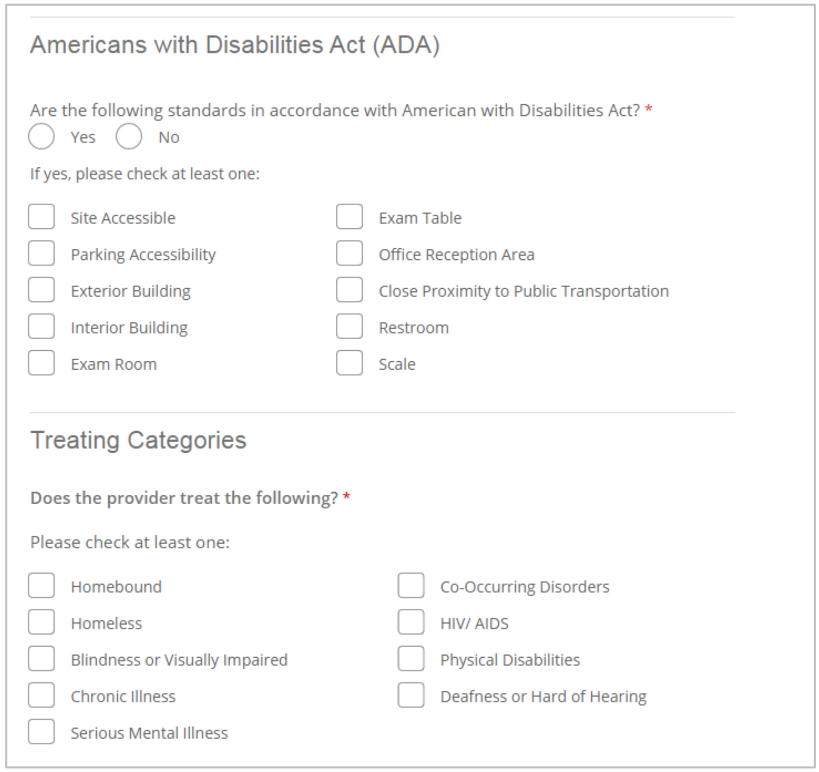
Tips for **Hours of Operation**

- 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.



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:

Site Accessible
Parking Accessibility
Exterior Building
Interior Building
Exam Room
Exam Table
Office Reception Area
Close Proximity to Public Transportation
Restroom
Scale

Treating Categories

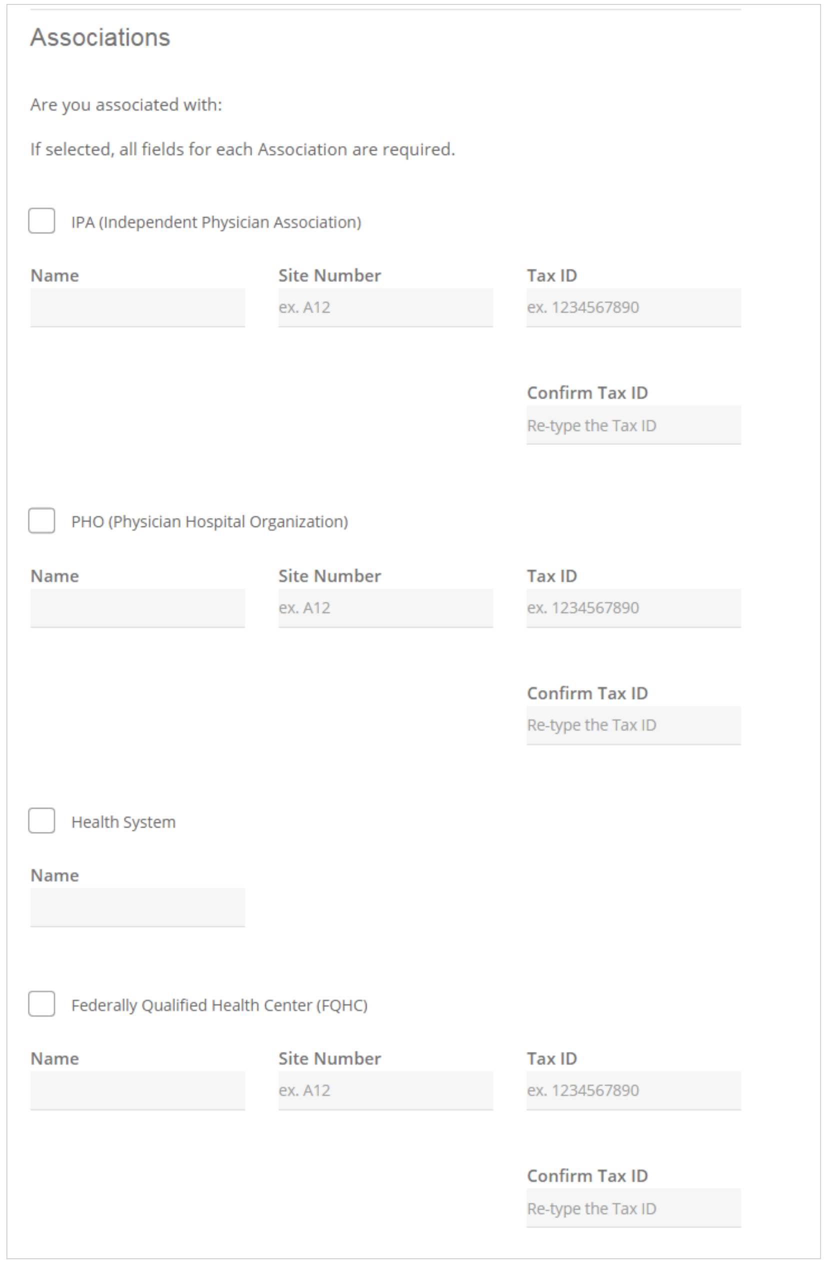
Does the provider treat the following? *

Please check at least one:

Homebound
Homeless
Blindness or Visually Impaired
Chronic Illness
Serious Mental Illness
Co-Occurring Disorders
HIV/ AIDS
Physical Disabilities
Deafness or Hard of Hearing

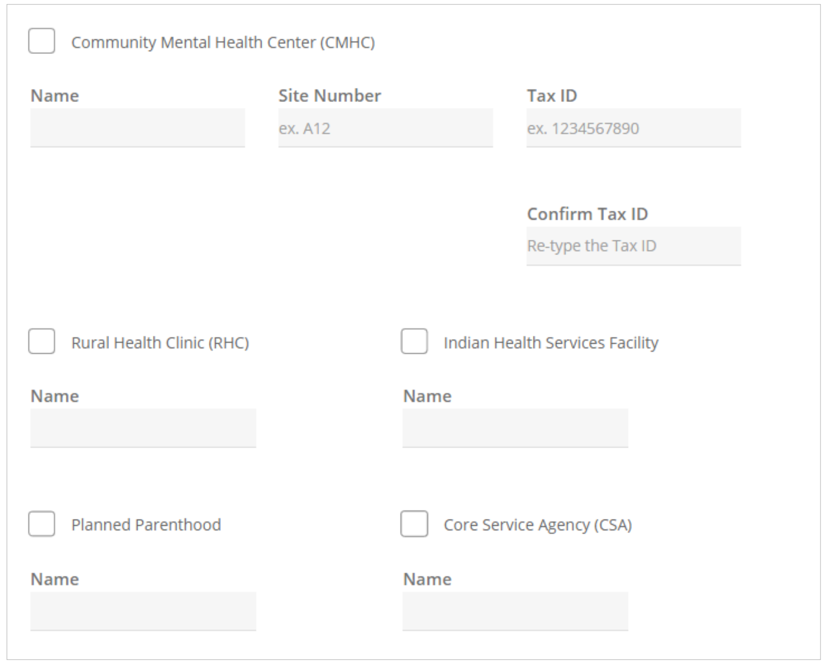
Office Physical Location – Continued

5. 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.



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.



7. Click **Save**.

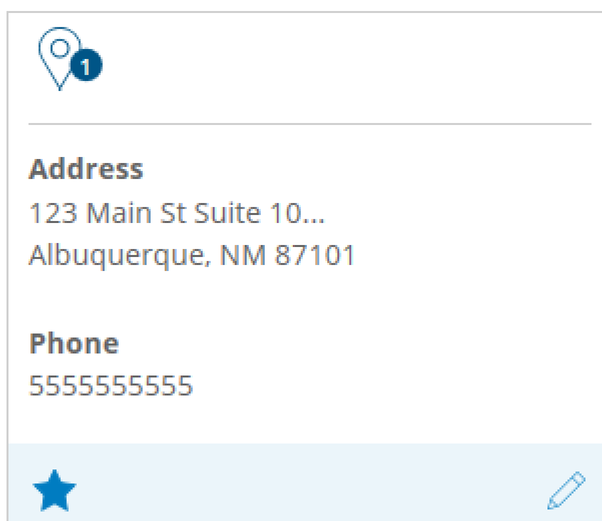
Note: It is important that you do this after creating each location. You will not be able to proceed with the enrollment process until the location is saved.

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

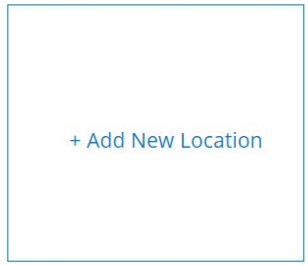
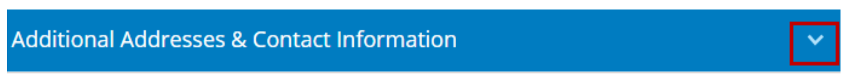
9. Review the information.

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

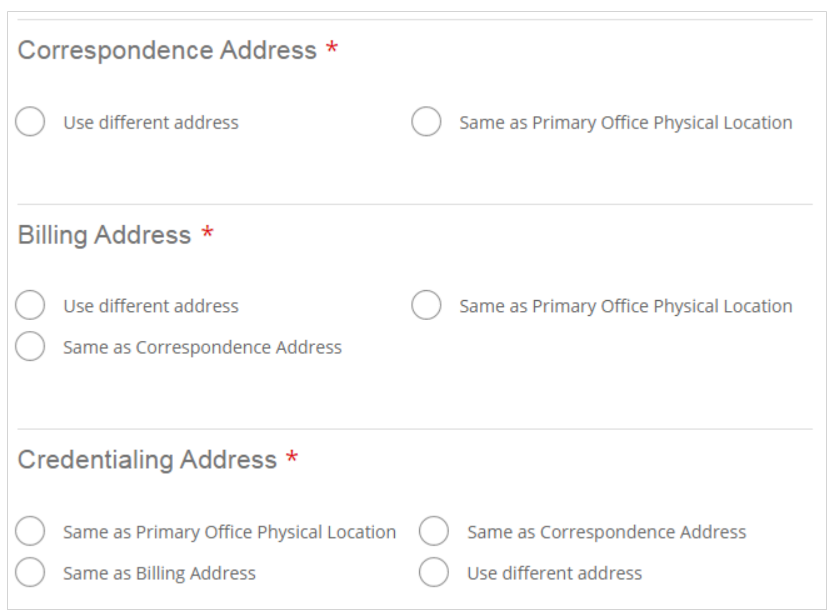
10. If you need to edit the information, click ✎. Don't forget to save your changes.



<table>
<tr><td>11. If you need to add additional locations, click the Add New Location button.

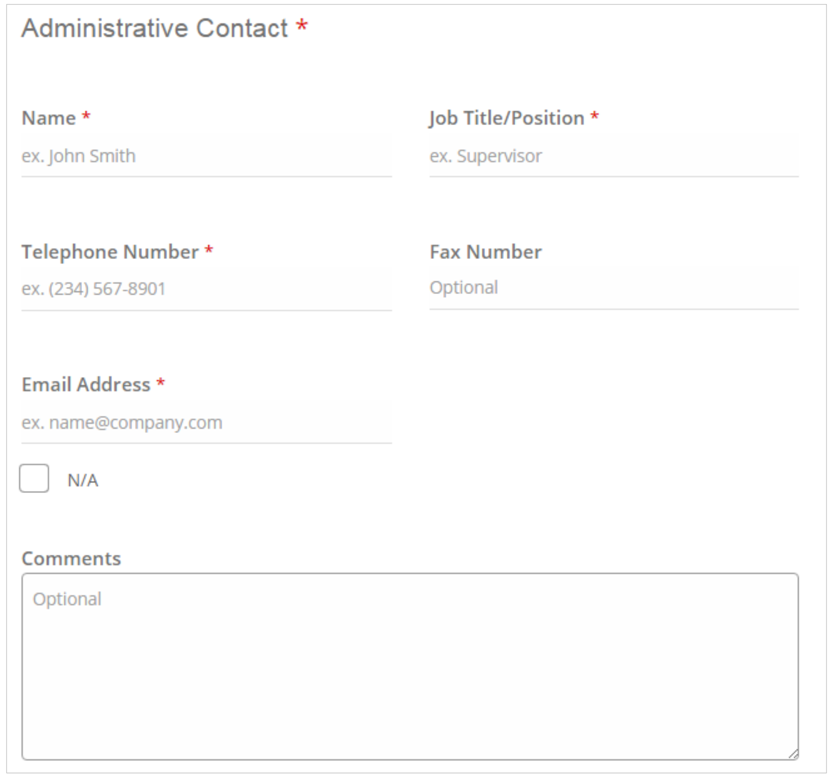
12. Complete the applicable information and click Save.</td><td>
</td></tr>
<tr><td>Cancel button cancels your changes and returns you to the Card View.</td><td>
</td></tr>
<tr><td>Delete button deletes the location.</td><td>
</td></tr>
<tr><td colspan="2"><h3>Additional Addresses & Contact Information</h3>Enter any additional addresses and contact information for the locations.</td></tr>
<tr><td>1. Open the section by clicking the arrow in the title bar.</td><td>
</td></tr>
<tr><td>You can enter different addresses for each of the address requirements or use the same address(es).

2. Designate which address to use by selecting the appropriate option for each address type.

3. If you chose to use a different address, you are prompted to enter it.</td><td>
</td></tr>
</table>

Additional Addresses and Contact Information – Continued

4. Enter the information for the Administrative Contact.

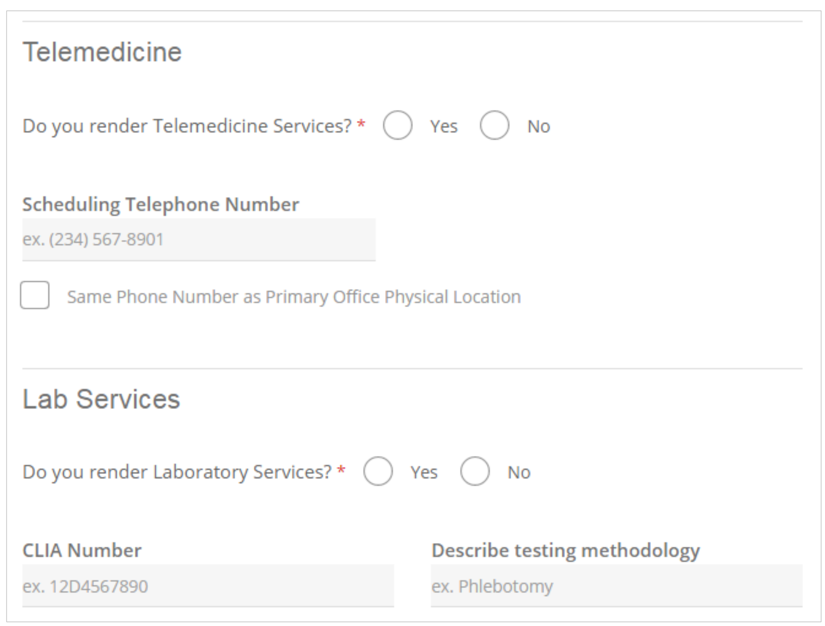


Practice Information

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

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

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.

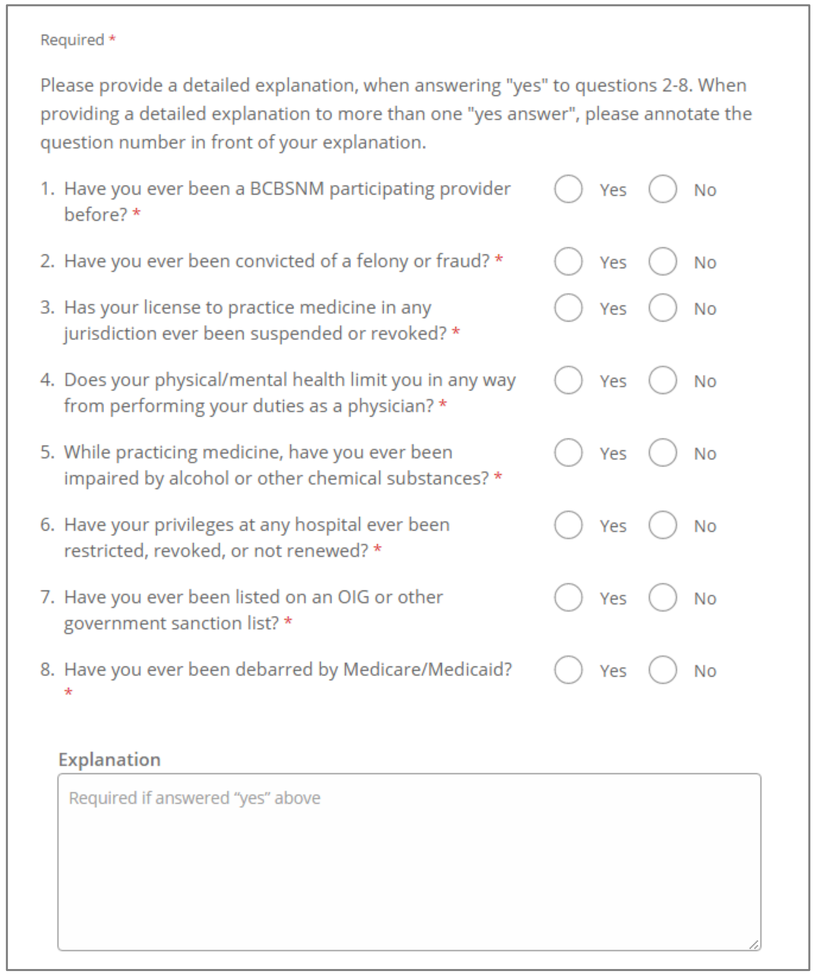


Questionnaire

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 *

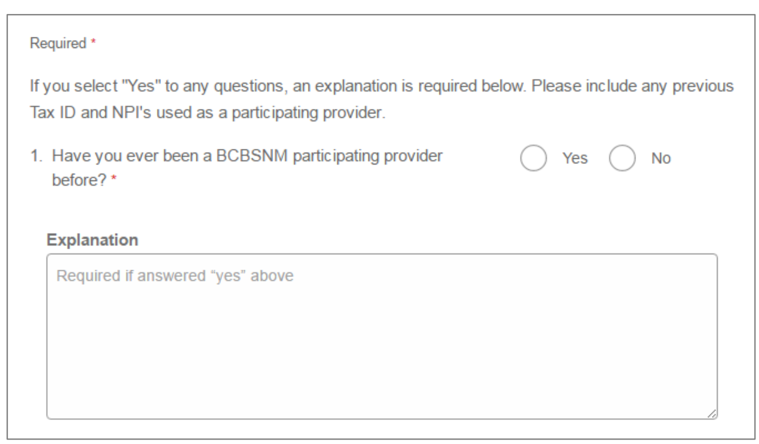
Please provide a detailed explanation, when answering "yes" to questions 2-8. When providing a detailed explanation to more than one "yes answer", please annotate the question number in front of your explanation.

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.

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.

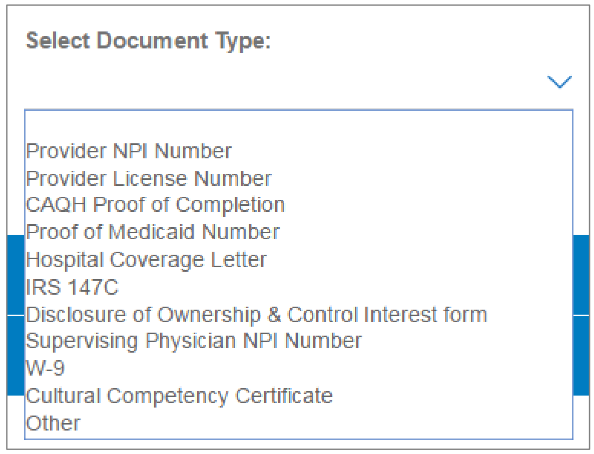
4. Locate the file on your hard drive and upload.

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

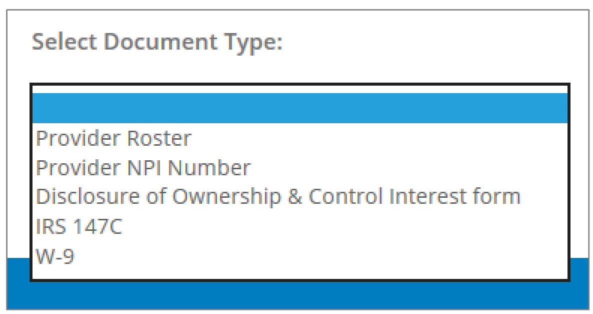
5. Repeat steps 2-4 for each document.

Attachment Tips

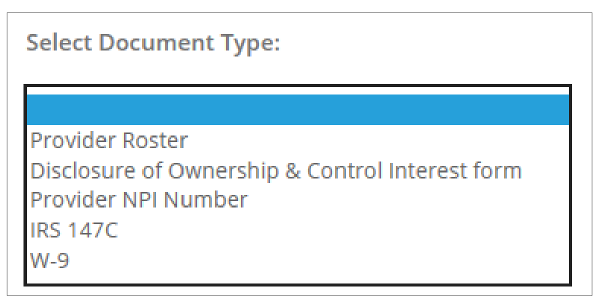
- Only attach the documents requested in the list.
- Size cannot exceed 5MB.
- File names cannot exceed 140 characters.
- File types accepted: .bmp, .doc, .docx, .gif, .jpeg, .jpg, .pdf, .png.



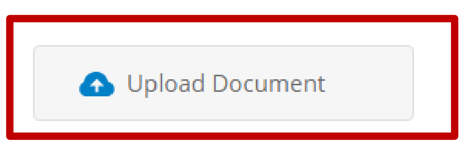
Solo Provider Document List



Group/Clinic Provider Document List



Add Provider to Existing Group/Clinic



6. If you uploaded a document in error, click Remove to delete it.

Comments

This section allows you to enter comments.

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

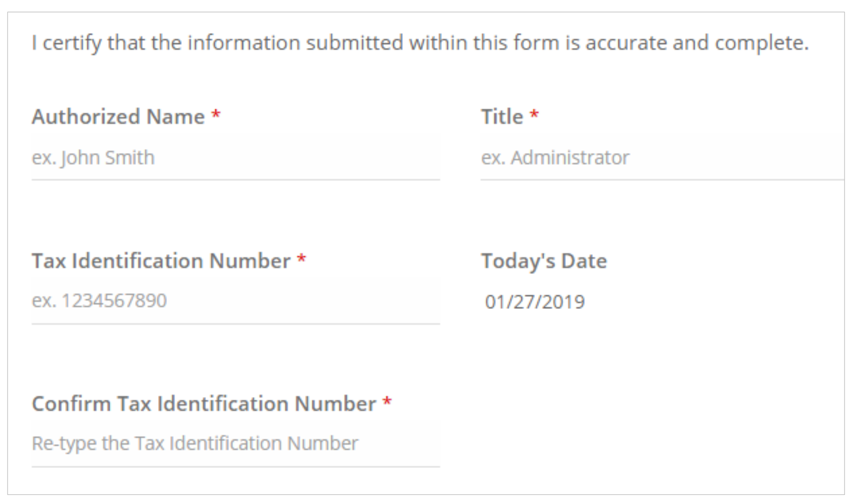
2. Type any comments, up to 2000 characters.

Attestation

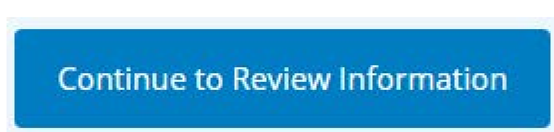
This section serves as your confirmation that all information entered is accurate and complete.

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

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.



3. Click the **Continue to Review Information** button to generate the enrollment form for your review.

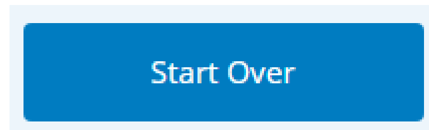


4 - Review and Submit

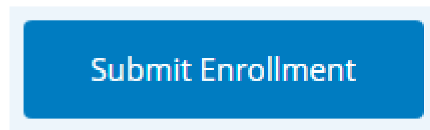
This section provides a summary of your enrollment form for your review.

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.

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.

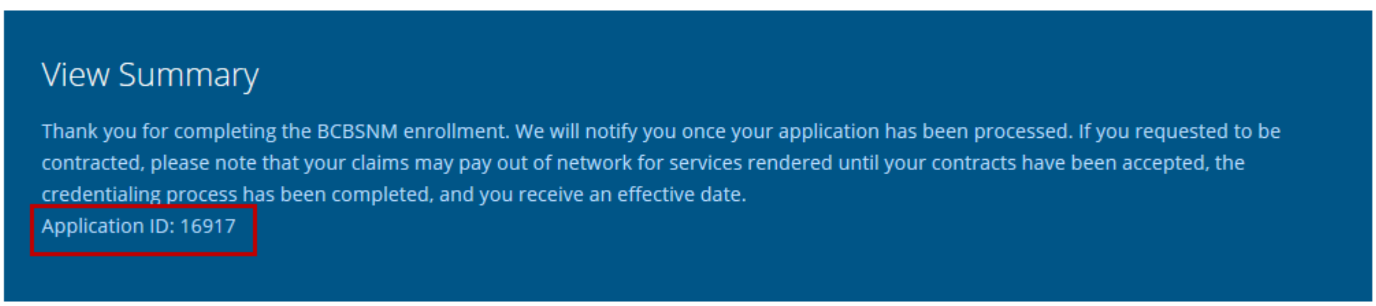


When you are sure all data is complete and correct, click Submit Enrollment.

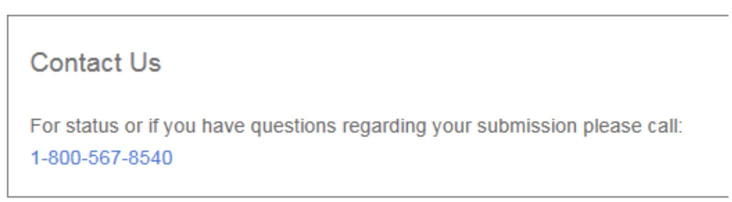


5 - View Summary

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.



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



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

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

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.

BlueCross BlueShield of New Mexico

Jane Test,

Thank you for contacting Blue Cross and Blue Shield of New Mexico.

This email is confirmation we have received your request, case number 00382780, for Jane Test.

Your request may take up to 30 days to complete. Once completed, a notification will be sent to the email address you provided during your submission.

To check on the status of your request or for any questions, please contact 1-800-567-8540 or contact your Network Representative.

Sincerely,
Blue Cross and Blue Shield of New Mexico

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Blue Cross and Blue Shield of New Mexico, a Division of Health Care Service Corporation,
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