Capital BLUE

Behavioral Health CBC Credentialing/ Contracting Activation Request NEW GROUP

Contract Relationship Add Request (Internal Use Only) ☐

Note: Please ensure the current Professional Liability Insurance Face Sheet for the new contract relationship(s) is included with this form. In addition, anything marked with an asterisk (*) is a required field.

Please complete the Areas of Expertise Form and return with this completed form. Please email the completed form to Capital BlueCross at CBC.CAICrecruiters@capbluecross.com.

Section 1—Provider Group Information

*Date:							
Note: If you are a third party billing company, submitting changes on behalf of a provider group, you will need to have the group complete an Attestation Form.							
*Legal Entity Name:							
Group Name (DBA*, if different from Legal Entity Name*):							
*Group NPI Number:							
*Group Tax ID Number:						Medicaid Promise ID: (if applicable)	
*Primary Office Street Address:						Suite Number:	
*Primary Office City:			*State:	*County:		*ZIP:	
*Primary Telephone Number:				Primary Fax Number:			
Group Email Address:							
*Primary Office Hours:	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Additional Office Location Street Address (affiliated with NPI/Tax ID listed above):						Suite Number:	
Additional Office City:			State:	County:		ZIP:	
Additional Office Appointment Phone Number:				Additional Office Fax Number:			
Additional Office Hours:	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
*Correspondence Address:							
*Correspondence Phone:				Correspondence Fax:			
*Remit Address:							
*Remit Phone: (If applicable)				Remit Fax: (If applicable)			
*Medical Records Address:							
*Medical Records Phone:				Medical Records Fax:			
*Medical Records Contact Person:				Medical Records Email:			

Please list those who are authorized to sign contracts on behalf of the practice:	
*Name:	*Title:
*Phone:	Fax:
*Email:	**Note:** This email address is used to communicate important information. It is your responsibility to notify Capital BlueCross of any changes.
Name:	Title:
Phone:	Fax:
*Group Contact Name:	*Group Contact Phone:
*Name and Title of Individual Completing this Form:	
*Email Address: ☐ Do not have an email address	*Taxonomy Code:

Please complete Page 2—Section 2 of this form for each new individual practitioner that is being added to the group in Section 1.

Using the CAQH Universal Provider DataSource does not grant participation or constitute applying for participation with any specific organizations. If you are already listed with CAQH, please ensure that you have authorized all applicable organizations to access your data.

Section 2—Individual Practitioner Information

*Last Name:	*First Name:	Middle Initial:
*Date of Birth:		
*Provider Type (MD, DO, LCSW, LSW, LPC, LMFT, Board Certified CNS, Behavior Specialist):		
*Specialty:		
*Languages:		
*Date Joined Group: **Note:** This does not mean this will be the actual effective date.		
*CAQH ID Number:	**Note:** Capital BlueCross requires practitioners to be registered with CAQH. So, if you are not already registered, please do so prior to submitting the Provider Data Form.	
*Social Security Number:	DEA Certificate Number:	
*State License Number:	*Licensed State:	
*Individual NPI Number:	*Taxonomy Code:	
*Will provider be practicing at all locations? ☐ Yes ☐ No (If provider will be at some, but not all locations, please list the locations below)		
Service Locations	Primary:	
	Other:	
	Other:	
	Other:	
	Other:	

***Criminal Background Check (*for ABA/Licensed Behavior Specialists only*):**
Criminal background check completed? ☐ Yes ☐ No
Criminal background check cleared (no adverse actions)? ☐ Yes ☐ No

***Signature:** _____
Form must be signed by the authorized contract signatory

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