Highmark Provider Form

*Please read the instructions below **before** completing this form, and mark a box for each action taken.* Please note that this form may be used for providers of Highmark Inc. ("Highmark") and certain affiliates: Highmark West Virginia Inc. ("Highmark WV"), Highmark Health Insurance Company ("HHIC") and Highmark BCBSD Inc. ("Highmark DE").

- ☒ **ALL** requests must complete **Sections 1 AND 6**.
- ☐ Adding or deleting a provider? Complete **Sections 1, 2, 3 AND 6**.
- ☐ Changing a main/practice/check/mailing address? Complete **Sections 1, 3 AND 6**.
- ☐ Changing a group name/DBA name/Tax ID? Complete **Sections 1, 5 AND 6**.
- ☐ Creating an Assignment Account (PA or DE) or Pay-To Account (WV)? Complete **Sections 1, 2, 3, 4, AND 6.**

SECTION 1 – Please complete for *all* requests.

Name of Account (DBA name) _____

Tax ID _____ *(Provide copy of Federal IRS Notification. W-9 is **NOT** acceptable.)*

Type 2 (Group) National Provider Identifier (NPI) _____ Highmark Group Number _____

SECTION 2 – Please complete if adding or deleting a practitioner. *(**Note**: For NaviNet users, changes should be made online.)*

If a practitioner needs to be credentialed, log on to the Provider Resource Center at www.highmark.com under "Provider Applications" and complete the "CAQH ID Request" to start the process.

Effective date of addition/change _____

Practitioner Name	***Date of Birth***	***CAQH ID***	***Type I NPI (Individual)***	***Practitioner Specialty***	***Add***	***Delete***
					○	○
					○	○
					○	○

SECTION 3 – Please complete for address changes or additions. *(**Note**: For NaviNet users, changes should be made online.)*

○Add ○Change **Main Practice** address ○Add* ○Change ○Delete **Practice** address(es)

○Add ○Change **Check** address ○Add ○Change **Mailing** address

Effective date of addition/change _____

Main Practice Address – Primary physical practice location *(PO Box numbers are **NOT** acceptable)*

_____ Practitioners at this location: _____

_____

Telephone number: ( ) _____

Fax number: ( ) _____ Member Access Number: ( ) _____ Patients call this number to make an appointment for this location

Office hours	*Monday*	*Tuesday*	*Wednesday*	*Thursday*	*Friday*	*Saturday*	*Sunday*

Practice Address 1 – physical location where patients receive services Practitioners at this location: _____

_____

_____

Telephone number: ( ) _____ Fax number: ( ) _____

Office hours	*Monday*	*Tuesday*	*Wednesday*	*Thursday*	*Friday*	*Saturday*	*Sunday*

Practice Address 2* – physical location where patients receive services Practitioners at this location: _____

_____

_____

Telephone number: ( ) _____ Fax number: ( ) _____

Office hours	*Monday*	*Tuesday*	*Wednesday*	*Thursday*	*Friday*	*Saturday*	*Sunday*

** Use a separate sheet for additional practice addresses.*

Mailing Address – if different than Main Practice and Check Address

_____

_____

_____

Telephone number: ( ) _____

Fax number: ( ) _____

Check Address – where checks are sent

_____

_____

Is this a lockbox? ○ Yes ○ No

Telephone number: ( ) _____

Fax number: ( ) _____

SECTION 4 – Please complete if requesting an Assignment Account (PA or DE) or a Pay-To Account (WV).

If a practitioner needs to be credentialed, log on to the Provider Resource Center at www.highmark.com under "Provider Applications" and complete the "CAQH ID Request" to start the process.

Is this request for: ☐ School-based clinic? ☐ Rural Health Clinic (RHC)? ☐ Federally Qualified Health Clinic (FQHC)?

Urgent Care Facility/ Retail Clinic Entities *only*
Please indicate if the requesting entity is: ○ Urgent Care Facility OR ○ Retail Clinic

Legal Entity Requesting Account – Please check one:
☐ Sole Proprietorship ☐ Partnership (General) ☐ Partnership (Limited) ☐ Non-Profit Corporation ☐ Business Corporation
☐ Professional Corporation ☐ Limited Liability Partnership ☐ Limited Liability Company (including restricted professional companies)
☐ Health Care Facility ☐ Other (explanation must be provided) _____

Relationship Between Legal Entity and Provider – Please check one:
☐ Employed Relationship ☐ Solo Practitioner ☐ Member/Shareholder ☐ Group billing under a Health Care Facility Tax ID
☐ General Partner ☐ Other (explanation must be provided) _____

Does the group employ CRNAs? ○ Yes ○ No If **YES**, complete the "CRNA Employment Status" on the Provider Resource Center at www.highmark.com and return.

Do you currently participate in QualityBLUE under another vendor affiliation? ○ Yes ○ No

If you are currently billing with another Assignment Account (PA or DE) or Pay-To Account (WV), will you be terminating that account?
○ Yes ○ No If **YES**, when? _____ (date)
Highmark ID of terminated Assignment Account (PA or DE) or Pay-To Account (WV): _____

If terminating an Assignment Account (PA or DE) or Pay-To Account (WV), are you still available to members at another location?
○ Yes ○ No
If **YES**, name and address of new location? _____
Effective date of new location? _____ (date)
If **NO**, please note that ***members will be notified of your network termination from the above-terminated group.***

NaviNet Contact Information – Please provide the name of your office staff that is responsible for NaviNet:
NaviNet Contact Name: _____
Telephone number: ( ) _____
Email address: _____

Do you currently have NaviNet with Highmark, Highmark WV, Highmark DE and/or HHIC or any other health insurance carrier?
○ Yes ○ No
If **YES**, please provide your NaviNet Username: _____ This information will be used to link your new number to your current NaviNet set up.

SECTION 5 – Please complete for group name / DBA name / Tax ID changes.

Provider Name Change
New name of group account: _____
Effective Date: _____

DBA Name Change
Existing DBA name: _____
New DBA name: _____
Effective Date: _____

Tax ID Change
Existing Tax ID: _____
New Tax ID _____
Effective Date: _____

NPI Change
Existing NPI: _____
New NPI: _____

SECTION 6 – Please complete for **ALL** requests. Please have the Authorized Representative sign below.

1. We hereby agree to only bill those services performed by providers in our account.
2. We certify that each member agrees to assign his/her fee to the group account.
3. We agree that every 1500 claim form submitted will include the provider number of the individual provider who actually performed the service (place in Block 24K of the claim or in any other location as determined in the future).
4. We agree that the group and each individual provider member will be jointly and severally liable for any overpayment that the group receives.
5. We agree to notify Highmark, Highmark WV, Highmark DE or HHIC (as each may be applicable) in writing of any subsequent changes in the composition of the group prior to the effective date of each change.
6. We agree to inform Highmark of any change in the group's contractual arrangements that directly or indirectly impact this Assignment Account (PA or DE) or Pay-To Account (WV) or that would necessitate Highmark, KHPW, Highmark WV, Highmark DE or HHIC payments to be made to some entity other than that designated in this Assignment Account (PA or DE) or Pay-To Account (WV) application.
7. [For PA providers only] We certify that we will not bill for any professional services that are reimbursed through another Pennsylvania Blue Cross Plan. All claims for these services will be submitted on the 1500 claim form for all appropriate Blue lines of business patients.
8. We understand that for certain networks all individual providers in the group must be fully credentialed in order for the group to be able to bill directly for that network and before rendering services to members.
9. We have carefully reviewed the forms and applications associated with the establishment of this agreement and each member has verified the accuracy and completeness of all information provided.
10. We have carefully reviewed the Highmark Provider Form and each member certifies and represents that the requested account will satisfy the requirements, and when established, that the account will not represent an ineligible arrangement as described in Part III of the Highmark Provider Form Regulations.

On behalf of the group, I certify that all providers have reviewed and agree to be bound by the Highmark Provider Form Requirements. I represent and warrant I have the authority to bind the individual providers and sign on their behalf.

By signing this Provider Form, we are agreeing to the Highmark Provider Form Regulations (version 1.0) found on the Provider Resource Center at www.highmark.com.

Signature of Authorized Representative of Group	Date
Title	( ) Telephone Number

Please fax the completed form to:
Provider Information Management at
(800) 236-8641