BlueCross BlueShield of Vermont

An Independent Licensee of the Blue Cross and Blue Shield Association.

Mail to: P.O. Box 186
Montpelier, VT 05601-0186

Fax: (802) 371-3489
Email: providerfiles@bcbsvt.com

Group/Independent Practice Enrollment/Change Form (GPECF)

Section 1: Reason for Form

- ☐ Add New Group Practice (*Date*)_____
  - ☐ I Intend to Contract
  - ☐ I Do Not Intend to Contract
- ☐ Physical Address and/or Phone Number Change
  - ☐ New
  - ☐ Moved (Old Address) _____
- ☐ **Date of Changes** _____

- ☐ Payment Address and/ or Phone Number Change
- ☐ Correspondence Address Change
- ☐ Change Group Tax ID Number (W-9 Required)
- ☐ Change Group Name (W-9 Required)
- ☐ Change Group NPI Number
- ☐ Other _____
- ☐ **Date of Changes** _____

Section 2: Office Information

Group Practice Name _____

Group Practice NPI Number _____ Taxonomy Code _____

Group Practice Office Hours _____ Group Practice Website _____

Are you a HCFA (Health Care Financing Adminstration) or UB (Universal Billing) billing practice? _____

Are you an Urgent Care Center? Yes____ No____

Are you an ECP (Essential Community Provider) Provider? Yes____ No____

Physical Address _____
Street

_____
City State ZIP

_____
Phone Number FAX Number

Payment Address _____
Street

_____
City State ZIP

_____
Phone Number FAX Number

Correspondence Address _____
Street

_____
City State ZIP

Tax ID Number _____
(W-9 or IRS SS-4 form required for new practices only. See instructions please.)

Section 3: Authorization and Contact Information

Contact Name *(Please print)* _____

Contact Phone Number _____

Contact E-mail Address _____

I certify that the above information is complete and accurate, and I agree, if a new provider is enrolling with this group, that the services the provider renders to Blue Cross and Blue Shield of Vermont (BCBSVT) members and members of BCBSVT's licensed affiliates will be provided according to the terms and conditions of the professional provider group contract, the physician-hospital organization contract, or the hospital contract (if provider is employed or contracted with a hospital), whichever is applicable, between such entity and BCBSVT and/or BCBSVT affiliate.

Authorized Signature _____ Date _____

BlueCross BlueShield of Vermont
An Independent Licensee of the Blue Cross and Blue Shield Association.

Mail to: P.O. Box 186
Montpelier, VT 05601-0186

Fax: (802) 371-3489
Email: providerfiles@bcbsvt.com

Instructions for Completing the Group/Independent Practice Enrollment/Change Form

Complete each section as it pertains. This form will be returned unprocessed if information or signature is missing. If you have any questions on how to complete this form, please call (888) 449-0443, option 2. Mail completed form to the address above or fax to the number above. **Note:** For complete enrollment and credentialing requirements, refer to the Provider Manual online at **www.bcbsvt.com**.

Reason for Form *Check the box(s) next to the action you are requesting.*	• **Add New Group Practice**—Adding a new group practice, complete all sections of this form. Effective date is subject to contracting and credentialing dates. • **I Intend to Contract**—Contacts have been signed and returned with this completed form. This is a participating group practice. • **I Do Not Intend to Contract**—Contacts are not included with this completed form. This is a non-participating group practice. • **Physical Address and/or Phone Number Change**—Used to update a physical location • **Payment Address or Phone Changes** —Used to update the payment address. • **Correspondence Address Change**—Used to update the correspondence address. • **Change Group Tax ID**- A new W-9 or SS-4 is required. • **Change Group Name**– A new W-9 or SS-4 is required. • **Change Group NPI Number**—Used to update an NPI number. Please indicate a future effective date. • **Other**—Used for any other changes to the group practice that are not already listed.
Office Information	• **Group Practice Name**—This is the name used to file taxes with the federal government. This name has to be consistent on all documents, including contracts and the W-9. **Note:** To ensure proper reimbursement in accordance with federal regulations, the group practice name provided in the business address section **must be identical** to that which is associated with the Tax ID Number used to report BCBSVT reimbursement. Failure to provide the proper business name may result in inaccurate reporting to the IRS. • **Group Practice National Provider Identifier (NPI Number)**—The number assigned to the practice by the Federal Government. • **Taxonomy Code**—List the taxonomy code associated with your NPI Number. • **Group Practice Office Hours**—The hours that the practice is open and seeing patients. • **Group Practice Website**—List any web addresses that the practice has online. • **Physical Location and Phone Number**—Physical address where services are rendered and listed in the directory. Complete a separate form (Section 2 only) for each additional location. • **Payment Address and Phone Number**—Address for remittance and payment only. If you use a third-party billing service, please provide written authorization for BCBSVT to communicate directly with the billing service. • **Correspondence Address**—To be used for all mailings except payments. Including but not limited to assignment agreements, contractual amendments, general information and updates. • **Tax ID Number**—As listed on the W-9 or the IRS SS-4 form.
Enrollment Contact Information and Authorization	• **Contact Name**—Name of the person responsible for provider enrollment and credentialing. • **Contact Phone Number**—Phone number to contact the enrollment person. • **Contact E-mail Address**—E-mail address of the contact enrollment person. • **Authorized Signature and Date Required**—Signature of the person with the authority to associate the new provider to the group practice contract.