Provider Network Enrollment Request

BlueCross BlueShield Kansas

Use this document to **request network enrollment forms** for a new provider or group contract. Any additional paperwork necessary will be sent to the office contact person you have indicated below for completion.

Fax or e-mail the completed request to:
Provider Network Services
Fax: (785) 290-0734
E-mail: Prof.Relations@bcbsks.com
Telephone: 1-800-432-3587 or (785) 291-4135, opt. 3
Attn: CC443D2, P.O. Box 239, Topeka, KS 66601

Behavioral Health Practitioners -
Complete and submit the Area of Expertise form with your network enrollment request.

Section 1 – Office Contact Information

Name of person to contact regarding enrollment if questions come up
First Name

Name of person to contact regarding enrollment if questions come up
Last Name

Title of person to contact regarding enrollment if questions come up
Office Contact Position/Title

(_____) _____-_____
Phone Number

(_____) _____-_____
Fax Number

Email of person to contact regarding enrollment if questions come up
E-mail Address

Section 2 – New Provider Information *(complete for each provider)*

Pharmacist first name
Provider's First Name

Pharmicist last name
Provider's Last Name

Gender ☐ Male ☐ Female

_____ /_____ /_____
Date of Birth

Location where pharmacist will render services
Location Address

If multiple locations, attached listing of addresses
City

_____ State
_____ ZIP Code
_____ +4
_____ Office Hours

(_____) _____-_____
Location Phone Number

(_____) _____-_____
Location Fax Number

CAQH # of Pharmacist
CAQH Provider ID Number (CAQH must be updated/reattested)

_____-_____-_____
Social Security Number

Tax ID # where services are rendered
Tax ID Number

Pharmacist NPI
Provider's NPI Number

NPI # where services are rendered
Billing NPI Number

Pharmacist
Provider's Specialty/Degree

NA
If provider is an APRN or PA, provide collaborating/supervising physician.
A supervising provider is also required for Athletic Trainers.

_____ /_____ /_____
Date provider will begin treating patients at this location

Will this provider be rendering telemedicine service? ☐ Yes ☐ No

Section 3 – New Group Contract

Business name i.e Pharmacy (who will get payment)
Entity Legal (W-9) Name

Entity/Corporation Owner(s), Partner(s), Investor(s)

Name you want in directory
Directory Name

Location where pharmacist will render services
Location Address

City

_____ State
_____ ZIP Code
_____ +4
_____ Office Hours

NA _ NA _ NA
Social Security Number

ax ID # where services are rendered
Tax ID Number

NPI # where services are rendered
Organizational or Subpart NPI Number(s) applicable

Pharmacy
Specialty

(_____) _____-_____
Location Phone Number

(_____) _____-_____
Location Fax Number

_____ /_____ /_____
Date patients will begin receiving services through this group

For each provider tied to the group, complete Section 2.
Attach additional pages for each location as needed.