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

First Name _____ (_____) _____-_____ Phone Number (_____) _____-_____ Fax Number

Last Name _____ E-mail Address _____

Office Contact Position/Title _____

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

Provider's First Name _____ CAQH Provider ID Number (CAQH must be updated/reattested) _____

Provider's Last Name _____ _____-_____-_____ Social Security Number _____ Tax ID Number

Gender ☐ Male ☐ Female _____ /_____ /_____ Date of Birth _____ Provider's NPI Number _____ Billing NPI Number

Location Address _____ Provider's Specialty/Degree _____

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

State _____ ZIP Code _____ +4 _____ Office Hours _____ _____ /_____ /_____ **Date provider will begin treating patients at this location**

(_____) _____-_____ Location Phone Number (_____) _____-_____ Location Fax Number

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

Section 3 – New Group Contract

Entity Legal (W-9) Name _____ _____-_____-_____ Social Security Number _____ Tax ID Number

Entity/Corporation Owner(s), Partner(s), Investor(s) _____ Organizational or Subpart NPI Number(s) applicable _____

Directory Name _____ Specialty _____

Location Address _____ (_____) _____-_____ Location Phone Number (_____) _____-_____ Location Fax Number

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

State _____ ZIP Code _____ +4 _____ Office Hours _____

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