Provider Network Application

BlueCross BlueShield Kansas

Use this form to **request consideration as a contracting network provider 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 email the completed request to:
Provider Network Enrollment
Fax: (785) 290-0734
E-mail: ProviderNetworkEnrollment@bcbsks.com
Telephone: 1-800-432-3587 or (785) 291-4135
Attn: CC443D2, P.O. Box 239, Topeka, KS 66601

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

HANDWRITTEN APPLICATIONS WILL NOT BE ACCEPTED

Section 1 – Office Contact Information

CLEAR DATA

First Name

(_____) _____-_____ Phone Number

(_____) _____-_____ Appointment Scheduling Number

Last Name

Email 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 NPI Number

Provider's Last Name

Billing NPI Number

Tax ID Number

Gender ☐ Male ☐ Female

_____ /_____ /_____ Date of Birth

Provider's Degree/Taxonomy (will be validated against NPPES registration to identify specialty)

Service Location Address

If provider is a PA, provide supervising physician. A supervising provider is also required for Athletic Trainers. Supervising physician must be contracting under same Tax ID.

City

State ZIP Code +4 Available days and hours (specify AM/PM)

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

(_____) _____-_____ Location Phone Number

(_____) _____-_____ Appointment Scheduling Number

Is the provider accepting new patients? ☐ Yes ☐ No

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

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

Section 3 – New Group Contract

Entity Legal (W-9) Name

Tax ID Number (EIN or SSN)

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

Organizational or Subpart NPI Number(s) applicable

Provider Directory Display Name

Specialty/Taxonomy (will be validated against NPPES registration)

Service Location Address

(_____) _____-_____ Location Phone Number

(_____) _____-_____ Location Fax Number

City

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

State ZIP Code +4 Available days and hours (specify AM/PM)

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