

Behavioral Health Contract Request Form (Effective April 2024)

Prior to completing this form, make sure that Blue Cross and Blue Shield of Minnesota (Blue Cross) is accepting contract requests for this location's specialty. You can find this information at <https://www.bluecrossmn.com/providers/join-our-network> **Note: This form must also be used to add an additional location or NPI.**

Fields marked with a **red!** are mandatory. Fields marked with a **blue!** are mandatory if the situation is applicable.

CONTACT INFORMATION (of the person completing this form)

! Name		! Email		Phone	
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! TYPE OF REQUEST (must select **one** option only)

New contract request (choose if the Tax ID for the group or location does not have a contract with Blue Cross)	<input type="checkbox"/>
New location, NPI, or specialty (choose if the Tax ID for the group or location has a contract with Blue Cross)	<input type="checkbox"/>
Other change (! describe):	<input type="checkbox"/>

GENERAL LOCATION INFORMATION (complete a separate contract request form for any additional locations)

! Legal business name			
! Doing business as (DBA) name (limit to 55 characters)			
! NPI or UMPI			
! Tax ID			
! Tax ID type	<input type="checkbox"/> Federal tax ID <input type="checkbox"/> Social Security number		
! Is this location tax exempt?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
! Has the Tax ID for this location recently changed?	<input type="checkbox"/> Yes ! explain		<input type="checkbox"/> No
! Has there been a recent merger or buyout of this location?	<input type="checkbox"/> Yes ! explain		<input type="checkbox"/> No
! Clinic email address (for any contracting documents) ! Legally authorized signer (for any contracting documents)			
Clinic website URL			

ADDRESSES

! Physical location address		Mailing address (complete if mail is not deliverable at the physical location address)		Pay-to address (complete if the billing address is different from the physical address)	
! Clinic effective date		Street		Street	
! Street		Suite		Suite	
! Suite		City		City	
! City		State		State	
! State		Zip		Zip	
! County				Phone	
! Zip					
! Appointments Phone Number					

SPECIALTY INFORMATION

! Specialty	
! Which format will this location use to submit claims?	<input type="checkbox"/> 1500/837P <input type="checkbox"/> UB/837I
What code(s) will this location be billing?	
! If this is a facility, list the specialty license(s) and/or certification(s) (e.g., 245G) AND provide a copy of the facility's license.	
! If this is a Medicare certified facility, list the Medicare# AND provide proof of Medicare certification.	

INFORMATION FOR PROVIDER DIRECTORIES

! Should the physical location address appear in the provider directory?	<input type="checkbox"/> Yes	<input type="checkbox"/> No (! explain)	
! Is this location accepting new patients?	<input type="checkbox"/> Yes	<input type="checkbox"/> No (! explain)	

Is this location, including parking, entry ways, and other relevant space accessible for people with disabilities?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are the exam rooms accessible for people with disabilities?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does your office have equipment accessible for people with disabilities?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does this location provide virtual/telehealth appointments?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Check all the options that apply to this location.	<input type="checkbox"/> American Sign Language (ASL)	<input type="checkbox"/> Braille materials	<input type="checkbox"/> Large print materials	<input type="checkbox"/> Learning headsets
	<input type="checkbox"/> Onsite interpreters	<input type="checkbox"/> Public transportation	<input type="checkbox"/> Qualified interpreters	<input type="checkbox"/> Remote video or telephonic interpreters
	<input type="checkbox"/> Taped text	<input type="checkbox"/> Tele-communication devices	<input type="checkbox"/> Television captioning devices	<input type="checkbox"/> Video text displays

Office Hours													
Mon Open	Mon Close	Tue Open	Tue Close	Wed Open	Wed Close	Thu Open	Thur Close	Fri Open	Fri Close	Sat Open	Sat Close	Sun Open	Sun Close

Have the staff at this location completed cultural competency training in the last 12 months?	<input type="checkbox"/> Yes (! list month and year)		<input type="checkbox"/> No
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DESIGNATIONS

Is this location a school that only provides student health services?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is this location enrolled with the Minnesota Department of Health (MDH) as an Essential Community Provider?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is this location designated as either a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is this location designated as a Certified Community Behavioral Health Clinic (CCBHC)?	<input type="checkbox"/> Yes <input type="checkbox"/> No

PROVIDER CAPABILITIES

! Is this location a solo practice/sole proprietorship?	<input type="checkbox"/> Yes <input type="checkbox"/> No
! If this is a solo practice/sole proprietorship, when did this solo practice open for business?	
! For locations that are not tax-exempt, list the owner(s) of this location along with their clinical title (e.g., MD, LMFT, etc.)	1.
	2.
	3.
	4.
	5.
What are the race and/or ethnicities of practitioners at this location? (optional information)	
! How many hours per week is this location open for business?	
! Where/How are services provided?	Designated office/clinic location Client's home Telehealth/Virtual Nursing Home Mobile <input type="checkbox"/> nit Other - please e ^x plain below:
! What percentage of appointments are held via telehealth or virtually?	
! Does this location provide Certified Peer Specialist services?	Yes No

! What percent of these groups make up this practice's caseload?	Group	
	Adolescents (ages 13-18) or Children (ages 3-12)	
	BIPOC	
	Geriatric (age 60+)	
	LGBTQ+	
	Veterans	
	EMTs, Law Enforcement, Health Care Providers	
Other (describe):		

AREAS OF EXPERTISE

Select the top three areas of expertise or focus at this location.	<input type="checkbox"/> Anxiety disorder treatment	<input type="checkbox"/> Attention deficit disorders	<input type="checkbox"/> Autism spectrum disorders
	<input type="checkbox"/> Behavior disorders	<input type="checkbox"/> Chronic pain management	<input type="checkbox"/> Cultural/Ethnic Issues
	<input type="checkbox"/> Compulsive gambling	<input type="checkbox"/> Developmental disabilities	<input type="checkbox"/> Eating disorder treatment
	<input type="checkbox"/> Geriatric	<input type="checkbox"/> Grief/Bereavement	<input type="checkbox"/> HIV/AIDS counseling
	<input type="checkbox"/> Infertility/Prenatal/Postpartum	<input type="checkbox"/> LGBTQ+ Counseling/Support	<input type="checkbox"/> Mood disorders
	<input type="checkbox"/> Obsessive compulsive disorders	<input type="checkbox"/> Organic brain or head injury	<input type="checkbox"/> Other compulsive disorders
	<input type="checkbox"/> Personality disorders	<input type="checkbox"/> Psychosomatic disorders	<input type="checkbox"/> Psychotic disorder treatment
	<input type="checkbox"/> PTSD	<input type="checkbox"/> Sexual issues counseling	<input type="checkbox"/> Substance use disorders
	<input type="checkbox"/> Veteran/Military Issues		

Select all applicable options.	Substance use disorder and behavioral health ages served	<input type="checkbox"/> Children (3-12)	<input type="checkbox"/> Adolescents (13-18)
		<input type="checkbox"/> Adults (19-59)	<input type="checkbox"/> Geriatric (60+)
	Substance use disorder and behavioral health restrictions	<input type="checkbox"/> Only serve males <input type="checkbox"/> Only serve females	
		<input type="checkbox"/> Care recovery	<input type="checkbox"/> Outpatient treatment
	Substance use disorder area of specialty	<input type="checkbox"/> Comprehensive assessment	<input type="checkbox"/> Residential treatment
		<input type="checkbox"/> Medication management	<input type="checkbox"/> Treatment coordination
		<input type="checkbox"/> Opioid treatment	<input type="checkbox"/> Withdrawal management

Select the top three interventions provided at this location.	<input type="checkbox"/> Bariatric assessment	<input type="checkbox"/> Cognitive behavioral therapy	<input type="checkbox"/> Couples therapy
	<input type="checkbox"/> Dialectical behavioral therapy (DBT)	<input type="checkbox"/> Early intensive developmental and behavioral intervention (EIDBI)	<input type="checkbox"/> Electro convulsive therapy
	<input type="checkbox"/> Esketamine treatment	<input type="checkbox"/> Exposure therapy	<input type="checkbox"/> Eye movement desensitization and reprocessing (EMDR)
	<input type="checkbox"/> Faith based therapy	<input type="checkbox"/> Family counseling	<input type="checkbox"/> First episode psychosis treatment
	<input type="checkbox"/> Medication assist treatment (for SUD) <input type="checkbox"/> Suboxone certified <input type="checkbox"/> Methadone maintenance provider	<input type="checkbox"/> Medication management	<input type="checkbox"/> Play therapy
	<input type="checkbox"/> Psychological Testing	<input type="checkbox"/> Transcranial magnetic stimulation	<input type="checkbox"/> Trauma therapy adults
	<input type="checkbox"/> Trauma therapy children		

MANDATORY ENROLLMENT WITH MINNESOTA HEALTH CARE PROGRAMS

Before a request for a contract can be considered, providers in the state of Minnesota must enroll with Minnesota Health Care Programs (MHCP).

MHCP is administered by the Minnesota Department of Human Services (DHS). The following must be enrolled:

1. All clinic or facility NPIs
2. Every clinic or facility location (if one NPI is affiliated with multiple locations)
3. All affiliated practitioners

Note: Enrolling with MHCP does not mean that providers have to contract with MHCP (although providers may do this if they wish)

! Is the NPI of the location on this contract request form either enrolled or contracted with MHCP?

Yes No

If “yes” was selected, please provide a copy of your MHCP Enrollment or Welcome Letter/Notification along with this request.

If “no” was selected, please enroll with MHCP, and do not submit this contract request form until you receive a MHCP Enrollment or Welcome Letter/Notification. Instructions for enrolling with MHCP can be found on DHS’s website: <https://mn.gov/dhs/partners-and-providers/enroll-with-mhcp/> Select “Enrollment process for Managed Care Organization (MCO) network providers”.

QUESTIONS

Please see our Provider Frequently Asked Questions document which answers the majority of administrative questions that providers have. The Provider FAQ can be found near the top of the following web page: <https://www.bluecrossmn.com/providers/network-participation/join-our-network>. If your question is not addressed, please contact Provider Service. Their number is included in the FAQ.

! By checking the following box, the person completing this form attests that the information provided above is true, accurate, and complete.

ADDITIONAL INFORMATION OR COMMENTS

Note: While we are unable to consider any appeals, we invite you to share any unique information about your practice you feel may be relevant.

Email completed forms and documentation to provider.enrollment.and.credentialing@bluecrossmn.com.