

The attached packet contains the forms required in order to be considered for network participation with Blue Cross Blue Shield of New Mexico. Please complete all applicable sections of the packet and return to NM Network Services by fax (preferred method) or by mail as indicated below.

The completed packet will be reviewed, and if accepted, the legal entity will receive a Medical Services Entity Agreement for signature, in the mail. Once a signed agreement is received, the credentialing process will be initiated. Upon approved credentialing status, provider will be added as a participating with the applicable lines of business and will be effective the date the provider is entered into the system. A fully executed copy of the agreement will then be sent to the legal entity.

If a provider is not accepted, a letter is sent to inform the provider they will not be added at this time, based on BCBSNM business needs.

**Billing Information:** Social Security Number and Federal Tax Identification Number must be completed in its entirety; the name that will appear on any reimbursement or Form 1099 will be that of the party to which payment is made. We will only make provider payments to the individual that rendered the service(s) and supplied a Tax Identification Number belonging to the named individual. To receive a Provider Record and/or join the BCBSNM network, please complete the Provider Record/ Contracting form below and the W-9 Form.

**PLEASE NOTE: Your assigned BCBSNM internal provider record does NOT mean that your organization is participating or that a contract will be offered.** Until your organization is credentialed and contract is executed with an effective date, all claims will be processed as out of network.

Please complete this packet and provide a copy of the following:

- Copy of all organizational licenses, registrations, certificates, etc. (for all locations that will be contracted by BCBSNM)
- Proof of professional liability insurance and amounts
- Service or program description
- Copy of Quality Assurance Program & annual evaluation of plan
- Most recent accreditation report or a copy of the Department of Health or CMS site visit (if not nationally accredited), if applicable
- Copy of licensure and/or certification of all applicable employees, if applicable
- Copy of the Letter 147C sent to you by the IRS or W-9
- Copy of letter or email from the Enumerator verifying NPI assignment, if applicable
- Copy of Medicaid and/or Medicare certification letters
- CRS-1 form (for-profit organizations only):
  - Taxpayer's copy of the CRS-1 form, or
- Information about any of the following:
  - Sanctions
  - Malpractice history and explanation
- License actions
- Medicaid Provider Disclosure of Ownership and Control Interest Form (**Legal Entity only**)

**Complete packet and return to:**

**FAX:** 1-866-290-7718 (toll-free) or 505-816-2688 (local)

**MAIL:** Blue Cross and Blue Shield of New Mexico  
Attention: Network Services Department  
P.O. Box 660058  
Dallas, TX 75266-0058

**PHONE:** Network Services at 1-800-567-8540 or  
505-837-8800

**WEBSITE:** Additional forms and information can be found on  
our website at <https://www.bcbsnm.com/provider>.



**Please Print:**

Facility/Agency/Vendor Name: \_\_\_\_\_

Specialty: \_\_\_\_\_

NPI (National Provider Identifier) #: \_\_\_\_\_ (if applicable)

Federal Tax ID Number: \_\_\_\_\_

List any languages spoken by you or your staff: \_\_\_\_\_

Does your facility have wheelchair access? Yes  No

Are you currently a Medicaid provider? Yes  No  If yes, in what state: \_\_\_\_\_

Medicaid number: \_\_\_\_\_

Are you a for-profit organization? Yes  No

If you are a for-profit organization, you are required to submit an approved CRS-1 form.  
See the required documents section on page 2.

**Physical Location:**

Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

Effective Date of this Address: \_\_\_/\_\_\_/\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Fax Number: \_\_\_\_\_ Fax No: \_\_\_\_\_

E-mail: \_\_\_\_\_

Business Office Manager: \_\_\_\_\_

(Please attach a separate sheet for any additional addresses, **including office hours and services performed.**)



**Mailing Address** (for correspondence):

Street/P.O. Box: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone No: \_\_\_\_\_ Fax No: \_\_\_\_\_

Contact Person: \_\_\_\_\_

**Billing Address** (for payments/checks):

Street/P.O. Box: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone No: \_\_\_\_\_ Fax No: \_\_\_\_\_

Contact Person: \_\_\_\_\_

Please describe your current service area: \_\_\_\_\_

\_\_\_\_\_

Participation will require the provider to submit claims directly to Blue Cross and Blue Shield of New Mexico.

What system of filing will you use?

CMS-1500 \_\_\_\_\_ UB 04 \_\_\_\_\_ Other (explain) \_\_\_\_\_

Have you ever been a BCBSNM participating provider before? Yes  No

Have you ever been debarred by Medicare/Medicaid? Yes  No

Has your company ever been listed on an OIG or other government sanction list? Yes  No

**If you answered yes to any of the above questions, please include a detailed letter of explanation.**

To the best of my knowledge, the information supplied on this document is accurate and complete.

Upon submission of this packet, provider hereby releases this information to Blue Cross and Blue Shield of New Mexico for the purpose of establishing a BCBSNM Provider Record.

I hereby represent and warrant that all information contained in this application is true, correct, and complete in all aspects.

I understand and agree that any misrepresentation in this application by omission or affirmative statement shall be grounds for termination.

Print Name: \_\_\_\_\_ Title: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# Disclosure of Ownership and Control Interest Form

**Purpose:** In compliance with 42 CFR 457.935, 42 CFR §455.104, §455.105, and §455.106, providers/disclosing entities are required to disclose including, but not limited to, information regarding (1) the identity of all persons with an ownership or control interest in the provider/disclosing entity, or in any subcontractor in which the provider/disclosing entity has a direct or indirect ownership of 5 percent or more including the identity of managing employees, and other disclosing entities; (2) certain business transactions and significant business transactions between the provider/disclosing entity and subcontractors/wholly owned suppliers; and (3) the identity of any person with an ownership or control interest in the provider/disclosing entity or who is an agent, or a managing employee of the provider/disclosing entity that has ever been convicted of any crime related to that person's involvement in any program under the Medicaid, Medicare, or Title XX program (Social Services Block Grants), or XXI (State Children's Health Insurance Program) of the Social Security Act since the inception of those programs. **Any authorized/designated representative of the provider/disclosing entity may complete and sign this form on behalf of the provider/disclosing entity.**

## Instructions for Completing the Ownership & Control Interest Disclosure Form

- 1) Read all definitions and instructions outlined throughout the form and then reference the definitions and instructions while completing the form. Terms with corresponding regulatory definitions are italicized and underlined throughout this form. Please review the applicable definition before responding to the question.
- 2) Definitions for Disclosure of Ownership and Control Interest Form - See Appendix A
- 3) Completion and submission of this statement/disclosure is a condition of participation as a credentialed or enrolled provider in the New Mexico Medicaid Managed Care Network or the State Children's Health Insurance Program (CHIP) network for services to members under Medicaid and CHIP benefit plans.
- 4) Answer all questions as of the current date i.e. request date.
- 5) If there is no information to include, indicate "None" or "Not applicable" (N/A) in the space provided. Do not leave blank spaces unless advised to do otherwise in the instructions. Incomplete forms will be reported back to HSD.
- 6) If more space is needed, please attach additional sheets.
- 7) In any space requesting 'Name,' if it is the name of an individual, include First, Middle and Last.
- 8) Business & Service Address: The address for corporate/legal entities must include, as applicable, the primary business address, every business location, and P.O. Box address. Individuals must provide their home address.
- 9) Provide the Employer Identification Number (EIN) or Tax Identification Number (TIN) for legal entities. Provide the Social Security Number (SSN) for individuals.
- 10) This statement/disclosure should be submitted with your MCO application, or at initial and renewal of a contract or agreement and any time there is a revision to the information. A statement must also be provided within **35** calendar days of a request for this information.
- 11) Failure to submit the requested information may result in denial of a claim, a refusal to enter into a provider agreement or contract, or in termination of existing provider agreements and contracts.

### How to Determine Ownership or Control Percentages (42 CFR 455.102).

- 12) Indirect ownership interest. The amount of indirect ownership interest is determined by multiplying the percentages of ownership in each entity. For example, if A owns 10 percent of the stock in a corporation which owns 80 percent of the stock of the disclosing entity, A's interest equates to an 8 percent indirect ownership interest in the disclosing entity and must be reported. Conversely, if B owns 80 percent of the stock of a corporation which owns 5 percent of the stock of the disclosing entity, B's interest equates to a 4 percent indirect ownership interest in the disclosing entity and need not be reported.
- 13) Person with an ownership or control interest. In order to determine percentage of ownership, mortgage, deed of trust, note, or other obligation, the percentage of interest owned in the obligation is multiplied by the percentage of the disclosing entity's assets used to secure the obligation. For example, if A owns 10 percent of a note secured by 60 percent of the provider's assets, A's interest in the provider's assets equates to 6 percent and must be reported. Conversely, if B owns 40 percent of a note secured by 10 percent of the provider's assets, B's interest in the provider's assets equates to 4 percent and need not be reported.

# Disclosure of Ownership and Control Interest Form

**NAME OF PROVIDER/DISCLOSING ENTITY BEING CONTRACTED:** \_\_\_\_\_

**NAME OF GROUP WHERE MEMBERS WILL BE SEEN:** \_\_\_\_\_

**TAX ID # OF PROVIDER/DISCLOSING ENTITY:** \_\_\_\_\_

**Section 1 – Disclosure Regarding Managing Employees (42 CFR 455.104(b) (4))**

1) Does the provider/*disclosing entity* have any *managing employees*?  Yes  No  
 If **Yes**, provide the following details for any *managing employee* of the provider/*disclosing entity*.  
 \*\*See the definition of *managing employee*\*\*

NAME	SSN	Birthdate	Complete Address (street/city/state/zip)	NPI	Position

**Section 2 – Criminal Offense Disclosure (42 CFR 455.106)**

2) Has the provider, or any *person* (individual or entity) *who has ownership or controlling interest* in the provider/*disclosing entity*, or who is an *agent* or *managing employee* of the provider/*disclosing entity*, ever been convicted of a criminal offense related to that person's involvement in any program established under Titles XVIII (Medicare), XIX (Medicaid), XXI (SCHIP), or Title XX (Social Services Block Grants) since the inception of those programs?  Yes  No (verify exclusion through the applicable federal and state specific exclusion databases.)

If **Yes**, provide the following details and a description of offense(s). Use additional pages if necessary.

NAME	SSN/TIN	Birthdate	Description

**Section 3 – Person(s) with Ownership or Control Interest Disclosure (42 CFR 455.104(b) (1))**

3) Are there any *persons* (individual or entity) *with an ownership or control interest* in the provider/*disclosing entity*?  
 Yes  No

If **Yes**, provide the following details and include the title (for example, CEO, owner, board member etc.).

\* For corporations/entities that have an ownership or control interest in the Disclosing Provider, please separately list its primary business address, every business location and post office box address.

\*\*See the definition of *person with an ownership or control interest* and *disclosing entity*\*\*

NAME	**TIN or SSN, as applicable	Birthdate	Title	Address (street/city/state/zip)	% Ownership Interest

**Section 4A – Direct or Indirect Ownership of 5% or More in a Subcontractor Disclosure (42 CFR 455.104(b) (1))**

# Disclosure of Ownership and Control Interest Form

4A) Does the provider/disclosing entity have a Direct or Indirect Ownership Interest of 5% or more in any Subcontractor?  
 Yes  No

If **Yes**, provide the following details about the subcontractor.

**\*\*See the definition of the following terms: subcontractor and indirect ownership interest\*\***

Name of Subcontractor	**TIN or SSN, as applicable	Birthdate	Address (street/city/state/zip)	% Ownership Interest

## Section 4B – Direct or Indirect Ownership of 5% or More in a Subcontractor Disclosure (42 CFR 455.104(b) (1))

4B) Does the provider/disclosing entity have a Direct or Indirect Ownership Interest of 5% or more in any Subcontractor?  
 Yes  No

If **Yes**, provide the information below about any person (individual or entity) with an ownership or control interest, in any subcontractor in which the provider/ disclosing entity has a 5 percent or more direct or indirect ownership or control interest.

**\*\*See the definition of the following terms: subcontractor and indirect ownership interest\*\***

Name of Subcontractor (from section 4A)	Name of Person(s) with an ownership or control interest in the <u>subcontractor</u>	**TIN or SSN, as applicable of Person(s) with an ownership or control interest in the <u>subcontractor</u>	Birthdate of Person(s) with an ownership or control interest in the <u>subcontractor</u>	Address (street/city/state/zip) of Person(s) with an ownership or control interest in the <u>subcontractor</u>	% Ownership Interest

## Section 5A – Relationships Disclosure (42 CFR 455.104(b) (2))

5A) Are any of the individuals disclosed in Section 3 above related to each other as a spouse, parent, child, or sibling?  
 Yes  No If **Yes**, provide the following details:

NAME(From Section 3)	Nature of Relationship (e.g., spouse)	Related to Name(From Section 3)

# Disclosure of Ownership and Control Interest Form

## Section 5B – Relationships Disclosure (42 CFR 455.104(b) (2))

5B) Are any of the individuals disclosed in **Section 3** above related to any of the individuals disclosed in **Section 4B** as a spouse, parent, child, or sibling?  **Yes**  **No** (spouse, parent, child, or sibling? If yes, give the name(s) of person(s) and relationship(s). Use additional pages if necessary. If **Yes**, provide the following details:

NAME(From Section 3)	Nature of Relationship (e.g., spouse)	Related to Name (From Section 4B)

## Section 6 – Other Disclosing Entity Disclosure (42 CFR 455.104(b) (3))

6.1) Does the provider/disclosing entity or any one named in Section 3 have an Ownership or Control Interest in any other Medicaid provider?  Yes  No  N/A

6.2) Does the provider/disclosing entity or any one named in Section 3 have an Ownership or Control Interest in any other disclosing entity that does not participate in Medicaid but is required to disclose certain ownership and control information because of participation in any of the programs established under Title V (Maternal and Child Health Services Block Grant), XVIII (Medicare), XX (Block Grants to States for Social Services) , or Title XXI (State Children’s Health Insurance Program) of the Social Security Act?  Yes  No  N/A

If Yes to Items 1 or 2 of this Section 6, provide the following details:

**\*\*See the definition of the following terms: other disclosing entity and ownership interest\*\***

NAME (From Section 3)	Name of <i>other disclosing entity</i> or <i>other Medicaid Provider</i>	SSN and/or TIN, as applicable of the <i>other disclosing entity</i> or <i>other Medicaid Provider</i>

## Section 7A – Business Transactions Disclosure (42 CFR 455.105)

**7A) Business Transactions - Subcontractors:** Has the provider/disclosing entity had any business transactions with a Subcontractor totaling more than \$25,000 in the previous twelve (12) month period (12-month period ending as of the date on this request)?  **Yes**  **No** If **Yes**, provide the following details:

**\*\*See the definition of subcontractor \*\***

Name of <i>subcontractor</i>	**TIN or SSN, as applicable of <i>subcontractor</i>	Birthdate	Address (street/city/state/zip)	Transaction Amount

# Disclosure of Ownership and Control Interest Form

## Section 7B – Significant Business Transactions Disclosure (42 CFR 455.105)

**7B) Significant Business Transactions:** Has the provider/disclosing entity had any Significant Business Transactions with a Wholly Owned Supplier or subcontractor during the previous 5-year period (5-year period ending as of the date on this request)?  **Yes**  **No** If **Yes**, provide the following details:

**\*\*See the definition of the following terms: subcontractor, wholly-owned supplier, and significant business transactions\*\***

Type of entity	Name	**TIN or SSN, as applicable	Birthdate	Address (street/city/state/zip)	Transaction Amount
<input type="checkbox"/> Wholly Owned Supplier					
<input type="checkbox"/> Subcontractor					
<input type="checkbox"/> Wholly Owned Supplier					
<input type="checkbox"/> Subcontractor					

## Section 8 – Attestation

8) Through signature below, I hereby certify that persons with ownership and control interest in the provider/disclosing entity or in a subcontractor, agents, subcontractors, managing employees, and any employees providing healthcare services as part of this application are screened with the applicable background check including, but is not limited to, verification against the applicable state and federal exclusion databases. I hereby represent and warrant that all information contained in this form is true, correct, and complete in all aspects. I understand that misleading, inaccurate, or incomplete data may result in a denial of participation or termination of an existing contract. I further understand completion of this form does not guarantee participation with the Managed Care Organization.

**Name:** \_\_\_\_\_ **Title:** \_\_\_\_\_  
 (Print or Type: First/Middle/Last) (Print or Type)

**Signature:** \_\_\_\_\_ **Date (MM/DD/YYYY):** \_\_\_\_\_  
 (Provider/Disclosing Entity or Authorized Agent of the Provider/Disclosing Entity)



# Disclosure of Ownership and Control Interest Form

## APPENDIX A

### DEFINITIONS

#	Term/Words	Definition
1	<i>Agent</i>	<b>Agent</b> means any person who has been delegated the authority to obligate or act on behalf of a provider. It also means any person who has express or implied authority to obligate or act on behalf of an entity (42 CFR 1001.1001).
2	<i>Disclosing entity</i>	<p><b>Disclosing entity</b> means a Medicaid provider (other than an individual practitioner or group of practitioners), or a fiscal agent.</p> <p>* For purposes of completing the Medicaid Disclosure Form, solo practitioners and the group contracting entity are also treated as a "disclosing entity."</p> <p>**Group Providers - The contracting group entity should complete the Form on behalf of the group.</p>
3	<i>Fiscal agent</i>	<b>Fiscal agent</b> means a contractor that processes or pays vendor claims on behalf of the Medicaid agency.
4	<i>Group of practitioners</i>	<b>Group of practitioners</b> means two or more health care practitioners who practice their profession at a common location (whether or not they share common facilities, common supporting staff, or common equipment).
5	<i>Health Insuring Organization (HIO)</i>	Health insuring organization (HIO) has the meaning specified in § 438.2.
6	<i>Indirect ownership interest</i>	<b>Indirect ownership interest</b> means an ownership interest in an entity that has an ownership interest in the disclosing entity. This term includes an ownership interest in any entity that has an indirect ownership interest in the disclosing entity. It also means an ownership interest through any other entities that ultimately have an ownership interest in the entity in issue (42 CFR 1001.1001). (For example, an individual has a 10 percent ownership interest in the entity at issue if he or she has a 20 percent ownership interest in a corporation that wholly owns a subsidiary that is a 50 percent owner of the entity in issue.)
7	<i>Managed care entity</i>	<b>Managed care entity (MCE)</b> means managed care organizations (MCOs), PIHPs, PAHPs, PCCMs, and HIOs. These terms are defined in 42 CFR § 438.2.
8	<i>Managing employee</i>	<b>Managing employee</b> means a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of, an institution, organization, or agency.

# Disclosure of Ownership and Control Interest Form

9	<i>Other disclosing entity</i>	<p>Other disclosing entity means any other Medicaid disclosing entity and any entity that does not participate in Medicaid, but is required to disclose certain ownership and control information because of participation in any of the programs established under title V, XVIII, or XX of the Act. This includes:</p> <ol style="list-style-type: none"> <li>a. Any hospital, skilled nursing facility, home health agency, independent clinical laboratory, renal disease facility, rural health clinic, or health maintenance organization that participates in Medicare (title XVIII);</li> <li>b. Any Medicare intermediary or carrier; and</li> <li>c. Any entity (other than an individual practitioner or group of practitioners) that furnishes, or arranges for the furnishing of, health-related services for which it claims payment under any plan or program established under title V or title XX of the Act.</li> </ol>
10	<i>Ownership interest</i>	<p><b>Ownership interest</b> means the possession of equity in the capital, the stock, or the profits of the disclosing entity. It also means an interest in:</p> <ol style="list-style-type: none"> <li>a. The capital, the stock or the profits of the entity, or</li> <li>b. Any mortgage, deed, trust or note, or other obligation secured in whole or in part by the property or assets of the entity.</li> </ol>
11	<i>Person with an ownership or control interest</i>	<p><b>Person with an ownership or control interest</b> means a person or corporation that:</p> <ol style="list-style-type: none"> <li>a) Has an ownership interest totaling 5 percent or more in a disclosing entity;</li> <li>b) Has an indirect ownership interest equal to 5 percent or more in a disclosing entity;</li> <li>c) Has a combination of direct and indirect ownership interests equal to 5 percent or more in a disclosing entity;</li> <li>d) Owns an interest of 5 percent or more in any mortgage, deed of trust, note, or other obligation secured by the disclosing entity if that interest equals at least 5 percent of the value of the property or assets of the disclosing entity;</li> <li>e) Is an officer or director of a disclosing entity that is organized as a corporation; or</li> <li>f) Is a partner in a disclosing entity that is organized as a partnership?</li> </ol>
12	<i>Prepaid ambulatory health plan (PAHP)</i>	Prepaid ambulatory health plan (PAHP) has the meaning specified in § 438.2.
13	<i>Prepaid inpatient health plan (PIHP)</i>	Prepaid inpatient health plan (PIHP) has the meaning specified in § 438.2.
14	<i>Primary care case manager (PCCM)</i>	Primary care case manager (PCCM) has the meaning specified in § 438.2.
15	<i>Significant business transaction</i>	<b>Significant business transaction</b> means any business transaction or series of transactions that, during any one fiscal year, exceed the lesser of \$ 25,000 and 5 percent of a provider's total operating expenses.
16	<i>Subcontractor</i>	<p><b>Subcontractor</b> means:</p> <ol style="list-style-type: none"> <li>a. An individual, agency, or organization to which a disclosing entity has contracted or delegated some of its management functions or responsibilities of providing medical care to its patients; or</li> <li>b. An individual, agency, or organization with which a fiscal agent has entered into a contract, agreement, purchase order, or lease (or leases of real property) to obtain space, supplies, equipment, or services provided under the Medicaid agreement.</li> </ol>

17	<i>Supplier</i>	Supplier means an individual, agency, or organization from which a provider purchases goods and services used in carrying out its responsibilities under Medicaid (e.g., a commercial laundry, a manufacturer of hospital beds, or a pharmaceutical firm).
18	<i>Termination</i>	<p><b>Termination</b> means –</p> <p>a) For a--</p> <ul style="list-style-type: none"> <li>i. Medicaid or CHIP provider, a State Medicaid program or CHIP has taken an action to revoke the provider's billing privileges, and the provider has exhausted all applicable appeal rights or the timeline for appeal has expired; and</li> <li>ii. Medicare provider, supplier or eligible professional, the Medicare program has revoked the provider or supplier's billing privileges, and the provider has exhausted all applicable appeal rights or the timeline for appeal has expired.</li> </ul> <p>b) (i) In all three programs, there is no expectation on the part of the provider or supplier or the State or Medicare program that the revocation is temporary.  (ii) The provider, supplier, or eligible professional will be required to reenroll with the applicable program if they wish billing privileges to be reinstated.</p> <p>c) The requirement for termination applies in cases where providers, suppliers, or eligible professionals were terminated or had their billing privileges revoked for cause which may include, but is not limited to-- (i) Fraud; (ii) Integrity; or (iii) Quality.</p>
19	<i>Wholly owned supplier</i>	<b>Wholly owned supplier</b> means a supplier whose total ownership interest is held by a provider or by a person, persons, or other entity with an ownership or control interest in a provider.