BlueCross BlueShield of Montana

HMK SCREENING APPLICATION FORM

Important Information Before Completing Form

This form only needs to be completed by those providers who are not currently enrolled in PECOS, Montana's Medicaid program, or another state's Medicaid or CHIP program. * Completion of this form does not guarantee enrollment in the HMK network.**

Individual's Personal Information

Last Name:	First Name:	MI:	Title:
Date of Birth:	Place of Birth:		Sex: M ☐ F ☐
Social Security Number:			
Foreign Language Spoken, including sign language:			
U.S. Citizen: Yes ☐ No ☐	If no, are you lawfully authorized to work in the U.S.? Yes ☐ No ☐		

Organization's Information * Please see page 8 for additional information

Organization Name:
Organization Website:

National Provider Identifier (NPI)

National Provider Identifier Number (Individual): If you do not have an NPI, you must obtain one prior to enrollment. This can be obtained at www.nppes.cms.hhs.gov

Tax ID

Federal Tax I.D.

Provider Specialty and Board Certification

Ambulatory Surgery Center ☐	Hospice ☐	Physician Assistant ☐
Birthing Center ☐	Hospital- Acute Care ☐	Podiatrist ☐
Certified Nurse Midwife ☐	Hospital- Critical Access ☐	Psychologist ☐
Certified Registered Nurse Anesthetist ☐	Laboratory ☐	Radiology Center ☐
Chemical Dependency Center ☐	Licensed Addiction Counselor ☐	Residential Treatment Facility ☐
Clinical Nurse Specialist ☐	Licensed Clinical Professional Counselor ☐	Skilled Nursing Facility ☐
Durable Medical Equipment ☐	Mental Health Center ☐	Speech Pathologist ☐
Freestanding Dialysis Center ☐	Occupational Therapist ☐	Other ☐
Home Health Agency ☐	Optometrist ☐	If Other Describe:
Home Infusion Therapy ☐	Physical Therapist ☐	

Physician (MD/DO) ☐	Primary Practicing Specialty	Board Certified: Yes ☐	No ☐
	Secondary Specialty	Board Certified: Yes ☐	No ☐

Physician Board Certification	Date Certified	Expiration Date
Name of Board:		
Name of Board:		

Practice Limitations

Patient Age:	Accepting Existing Patients Only: Yes ☐ No ☐

Practice Address (P.O. Boxes Are Not Acceptable for the Physical Address)

Practice Name:		Type: ☐ Solo ☐ Group ☐ Organization	
Physical Address 1:	City:	ST	Zip:
Physical Address 2:	City:	ST	Zip:
Physical Address 3:	City:	ST	Zip:
Office Phone:	Office Fax:	Office Email: Required for official BCBSMT correspondence	
Mailing Address:	City:	ST	Zip:
☐ Same as above			
Office Phone:	Office Fax:		
Billing Address:	City:	ST	Zip:
☐ Same as above			
Office Phone:	Office Fax:		

Business Hours						
Monday	Tuesday	Wednesday	Thursday	Friday	Sat/Sun/Holiday	Evenings

Does the office comply with the Americans with Disabilities Act (ADA) Standards?	Yes ☐ No ☐
Start date at this location:	

Primary office contact:		Title:		Phone:	

Contact Information for Enrollment

Contact Name:		Phone:		E-Mail:	

Licenses/Certifications

Current Licenses Held

State Issued By	Number	Original Issue Date	Expiration Date

Previous Licenses Held

State Issued By	Number	Original Issue Date	Expiration Date

Have you ever had any action or sanction against your license in any state? Yes ☐ No ☐ If Yes, which State?
If yes, indicate action: Revoked /Suspended ☐ Letter of Reprimand ☐ Fines Assessed ☐ Education Required ☐ Probation ☐

CLIA Number (If applicable)

CLIA Number	Effective Date	Expiration Date

DEA Certification

DEA Number	Issue Date	Expiration Date

Medicare/Medicaid

Are you enrolled in Medicare, Montana Medicaid or another state's Medicaid or CHIP Program?		Yes ☐ No ☐
If yes, which program state and date? Medicare ☐ MT Medicaid ☐		
Another State's Medicaid Yes ☐ No ☐	State:	Date:
Another State's CHIP: Yes ☐ No ☐	State:	Date:

Have you had site visits in accordance with your enrollment with Medicare, MT Medicaid or another state's Medicaid or CHIP program? Yes ☐ No ☐
If yes, indicate which program, state and date:
Medicare ☐ MT Medicaid ☐ Another State's Medicaid ☐ Other State's CHIP ☐
State: Date:

Have you paid an enrollment fee to Medicare, MT Medicaid or another state's Medicaid or CHIP program? Yes ☐ No ☐
If yes, indicate which program, state and date:
Medicare ☐ MT Medicaid ☐ Another State's Medicaid ☐ Other State's CHIP ☐
State: Date:

Have you been revalidated by Medicare, MT Medicaid or another state's Medicaid or CHIP program? Yes ☐ No ☐
If yes, indicate which program, state and date:
Medicare ☐ MT Medicaid ☐ Another State's Medicaid ☐ Other State's CHIP ☐
State: Date:

Have you ever been sanctioned, debarred, suspended, excluded or convicted of a criminal offense related to Medicare, Medicaid, or another State or Federal program? Yes ☐ No ☐
If yes, enter explanation and dates:

Ownership/Control Information

***** NOTE: This section must be completed for each person who has a direct or indirect ownership and/or controlling interest in the entity and/or provider type specified on page 8 of this screening application.** This section must also be completed for each managing employee or agent of the enrolling entity and/or provider. All other provider types can skip to page 7.

Ownership interest means the possession of equity in the capital, the stock, or the profits of the disclosing entity (provider).

Indirect ownership interest means an ownership interest in an entity that has an ownership interest in the disclosing provider entity. The term includes an ownership interest in any entity that has an indirect ownership interest in the disclosing entity (provider).

A person with an ownership or control interest means a person or corporation that (a) has an ownership interest totaling 5% or more in a disclosing entity (provider); (b) has an indirect ownership interest equal to 5% or more in a disclosing entity (provider); (c) has a combination of direct and indirect ownership interests equal to 5% or more disclosing entity (provider); (d) owns an interest of 5% or more in any mortgage, deed of trust note or other obligation secured by the disclosing entity (provider) if that interest equals at least 5% of the value of the property or assets of the disclosing entity (provider); (e) is an officer or director of a disclosing entity (provider);that is organized as a corporation; or (f) is a partner in a disclosing entity (provider); that is organized as a partnership.

(a) *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.

(b) *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.

Managing employee 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.

An agent means any person who has been delegated the authority to obligate or act on behalf of a provider.

Ownership/Control Information Form

At least one person must be added as owner. For multiple owners, please copy this form and complete one form for each owner.

Ownership Type

☐ Owner	☐ Agent	☐ Managing Employee	☐ Subcontractor

Last Name:	First Name:	MI:
Date of Birth:	Social Security Number:	
Country of Birth:	Country of Birth (if country of birth is USA):	

Physical Address

Practice/Group Name:		
Address:		
Address 2:		
City:	State:	Zip:
County:	Telephone:	

Mailing Address (if different from Physical Address)

Practice/Group Name:		
Address:		
Address 2:		
City:	City:	City:
County:	County:	

Provider Number:

Ownership

Are you the spouse, parent, child, or sibling of a person with ownership or control interest? Yes ☐ No ☐
Name of person with ownership or control interest:

Sanctions

Are you currently, or within the past 10 years have you been sanctioned, debarred, suspended, excluded or convicted of a criminal offense related to Healthy Montana Kids/Medicare/Medicaid or any other State or Federal program? Yes ☐ No ☐
If yes, provide explanation:

Ownership/Control Information Form

Do you have ownership or control interest of 5 percent or more in another organization that participates in publicly funded health care programs? Yes ☐ No ☐

If yes, complete the information below

Legal Business Name:		SSN/EIN:
Address:		
Address 2:		
City:	State:	Zip:

Legal Business Name:		SSN/EIN:
Address:		
Address 2:		
City:	State:	Zip:

Legal Business Name:		SSN/EIN:
Address:		
Address 2:		
City:	State:	Zip:

Legal Business Name:		SSN/EIN:
Address:		
Address 2:		
City:	State:	Zip:

Attestation

I,
(Type full name)

hereby certify and attest that all the information submitted by me in support of this enrollment application is true, accurate and complete to the best of my knowledge and belief. I understand and agree that substantial errors of fact involving information submitted by me may be the basis for rejection of my application or, if discovered after approval of my application, for adverse action up to and including termination.

_____ Date: _____
Signature

Contact Information

Scan and email a signed, completed enrollment application and attachments to HCSSPEC@bcbsmt.com, and keep a copy for your records. If email is not available, applications and the attachments can be faxed to (406) 437-7879 Attention: Network Management or mailed to:

Network Management
Blue Cross and Blue Shield of Montana
P.O. Box 4309
Helena, MT 59604

For questions, please e-mail HCS-x6100@bcbsmt.com or call 1-800-447-7828 ext. 6100.

*Application Fee Requirements for HMK Providers**

Provider Type	Initial Enrollment	Revalidation	Change of Ownership **	Change of Information	Addition of Practice Location
Ambulatory Surgery Center (ASC)	Yes	Yes	No	No	Yes
Community Mental Health Center	Yes	Yes	No	No	Yes
Critical Access Hospital	Yes	Yes	No	No	Yes
Durable Medical Equipment Supplier, Prosthetics, Orthotics, and Supplies	Yes	Yes	No	No	Yes
End Stage Renal Disease Facility (ESRD)	Yes	Yes	No	No	Yes
Histocompatibility Laboratory	Yes	Yes	No	No	Yes
Home Health Agency	Yes	Yes	No	No	Yes
Hospice	Yes	Yes	No	No	Yes
Hospital	Yes	Yes	No	No	Yes
Independent Diagnostic Treatment Facilities (IDTFs) including: • Radiology Center • Sleep Centers	Yes	Yes	No	No	Yes
Independent Clinic Laboratory	Yes	Yes	No	No	Yes
Pharmacy	Yes	Yes	No	No	Yes
Skilled Nursing Facility	Yes	Yes	No	No	Yes

Requirements per CFR 455.460 and Title XIX of the Social Security Act 1886 (j) (2) (c)

The 2018 Fee is $569 and must be collected prior to becoming active with HMK network.

Fees are determined by CMS and may change annually.

* Providers verified in PECOS, MT Medicaid, or another State's Medicaid or CHIP Program are not required to pay the application fee.

****** For providers reporting a change of ownership, the ownership change does not require an application fee if the change does not require the provider to enroll as a new provider.

Please make a check payable to Blue Cross Blue Shield of MT and return to:

Network Management
PO Box 4309
Helena MT 59604