New Professional Provider Contracting for Anthem BCBS of Kentucky

Provider Enrollment Form Checklist for:

1. **Credentialing**:

   □ Each provider (if applicable) must complete a CAQH application.
   https://proview.caqh.org/Login/Index?ReturnUrl=%2f

   CAQH ProView Support Desk Phone: 1-888-599-1771
   Email: providerhelp@proview.caqh.org

2. **If adding a provider to an existing practice, you only need to complete the Provider Maintenance Form (PMF)**: ****Use when adding a provider to an existing group, Terms, Demographic Updates**

   □ PMF must be completed, please go to: https://central.provider.anthem.com/mwpmf/PMFControllerServlet

   □ If you submit claims under multiple Group NPIs please submit a PMF for each Group NPI.

   *If you employ a Physician Extender, please make sure in Section C you indicate whether the Physician Extender is supporting a Primary Care or Specialist practice.

3. KY Professional Provider Enrollment Form: **Only needed for New Contracts or New EIN

The enrollment form can be returned either by Email **OR** Fax
We also need a signed **W-9** for the new tax ID. Select this link for a copy of a blank W-9:
https://www.irs.gov/pub/irs-pdf/fw9.pdf

Email the Enrollment Form and W-9 to: KYProviderContracting@anthem.com
Fax the Enrollment Form and W-9 to (855) 384-4872.

4. Anthem Kentucky Medicaid:

Eligible providers must be enrolled through the state and **have an active KY Medicaid number.**
Eligible providers must participate with **KY Health Information Exchange (KHIE).** If you are not registered, please enroll as soon as possible at their website- https://khie.ky.gov/Get-Started/Pages/default.aspx

5. Indiana Medicaid plans:

Hoosier Healthwise/Hoosier Care Connect -Eligible providers must be enrolled with the state and **have an active Indiana Medicaid number.**
Healthy Indiana – **Eligible** providers must be enrolled with the state and **have an active Indiana Medicaid number.**

6. Enrollment for Electronic Funds Transfer and Electronic Remittance Advice (EFT) and (ERA)

For EFT, once your Provider Contract and EIN are set up in the Anthem system you will have access to set up your EFT EnrollSafe through **https://enrollsafe.payeehub.org** and **select register.**
For ERA, please register through Availity**: https://www.availity.com/**

Providers can access the Anthem Kentucky Provider Portal through the link below, all provider communications can be accessed through this link including updates to the Provider Manual:

Professional Provider Enrollment Form

(For Kentucky Pharmacy Contracting only)

https://www.anthem.com/provider/getting-started

This form should only be completed for NEW Pharmacy practices wanting to contract with Anthem Blue Cross Blue Shield in KY.

I, the undersigned, submit this application to Anthem Blue Cross Blue Shield to determine eligibility to become a participating provider. I understand that this application does not entitle me to participate in the provider network(s). Should I be accepted for participation status, I understand that I will have to abide by the provisions of the Participating Provider Agreement, which will be made available to me prior to contracting. All information is true and correct as submitted.

_____
(Group dba name)

_____
(Authorized Signature) **(Print Name and Title)**

- ☐ **Federal Tax ID#** _____
- ☐ **Group NPI #**_____

Please select the Anthem Kentucky BCBS networks you are applying for:

- ☐ **Blue Preferred – HM0**
- ☐ **Blue Access – PP0**
- ☐ **Blue Traditional**
- ☐ **KY Pathway Blue High-Performance Network (HPN) Must have physical location in Kentucky**
- ☐ **KY Pathway HMO**

GENERAL INFORMATION

Primary Practice Address: _____
(Physical location) Street Address (include suite number)

_____
City State Zip Code County

Telephone Number: _____

Fax Number: _____

- ☐ **Remit Address is the same**

Remit/Payment Address:_____
(Complete if different) Street Address or Post Office Box

Professional Provider Enrollment Form

(For Kentucky Pharmacy Contracting only)

City State Zip Code County

Telephone Number: (___) _____

Fax Number: (___) _____

For additional locations, attach a list including the name, address, telephone number, Federal Tax ID number, KY Medicaid Group number, Group NPI #, roster of practitioners and practice locations.

Primary Contact:_____ Title:_____

Contract mailing address: _____City _____State _____ZIP _____

Telephone Number: _____ Fax Number: _____

Email Address to send the Contract: (email) _____

Please return the completed enrollment form and a signed W-9 for the new tax ID by Fax or Email.

Email the Enrollment Form and W-9 to KYProviderContracting@anthem.com or
Fax the Enrollment Form and W-9 to (855) 384-4872.

Select this link for a copy of a blank W-9:
https://www.irs.gov/pub/irs-pdf/fw9.pdf

Comments: _____

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