Excellus

A nonprofit independent licensee of the Blue Cross Blue Shield Association

Application for Non-Physician Health Care Practitioner

This application is only used for participation with Excellus Health Plan.

Copies of your diploma, licenses, malpractice (liability) insurance, and W-9 must be attached. Enrollment will not be processed without this documentation.

All fields must be completed.

Requested Effective Date:				
Request type:	☐ First-time application	☐ Join a new tax ID	☐ Demographic change	☐ Sponsor change
Applying as:	☐ Nurse Practitioner	☐ Physician Assistant	☐ Registered Nurse First Assistant	
☐ Certified Behavior Analyst Assistant	☐ Licensed Master Social Worker (LMSW)	☐ Licensed Creative Arts Therapist (LCAT)	☐ Psychoanalyst	

Last Name:	First Name:	Middle Initial:
Date of Birth:	Gender: ☐ Female ☐ Male	
Social Security #:	Individual NPI #:	
Non-Physician Taxonomy Code:		
License #:	License State:	
DEA Certification #:	DEA Certifcation State:	
Medicare #:	Medicaid #:	To be enrolled in Medicaid products, an active Medicaid ID is required (does not apply to Psychoanalysts, LMSW or LCAT).
Language(s) spoken other than English:		

Race/Ethnicity - *for reporting purposes only.*			
American Indian or Alaskan Native (Not Hispanic or Latino)	☐	Other	☐
Asian (Not Hispanic or Latino)	☐	Prefer Not to Say	☐
Black or African American (Not Hispanic or Latino)	☐	Two or More Races (Not Hispanic or Latino)	☐
Hispanic or Latino	☐	White/Caucasian (Not Hispanic or Latino)	☐
Native Hawaiian or other Pacific Island (Not Hispanic or Latino)	☐		

☐ "I attest that I have completed 3,600 hours of experience as a licensed or certified NP 1-in accordance with the laws of New York or another state or 2-while employed by the United States veteran's administration, armed forces or public health service. Therefore, I do not require a collaborating provider."

If yes, please leave the Collaborating Physician fields blank.

Collaborating physicians must participate with the Health Plan. Additionally, the collaborating physician for Psychoanalysts, LMSWs and LCATs must be a licensed clinical social worker with the "R" designation (LCSW-R), psychologist (PhD) or psychiatrist (MD).

Collaborating Physician Name:	
Collaborating Physician NPI #:	
Group Name:	Group NPI #:
Tax ID #:	Specialty:

Proceed to Page 2 for additional required information.

Office addresses must be identified by street level information with the corresponding City, State and ZIP Code. PO BOX information is not allowed. Please provide only ONE Correspondence, ONE Remittance, and ONE Medical Records address. Each address can be the same or different, but must be identified as a valid United States Postal Service mailing address. If PO BOX information is used, the corresponding City, State and ZIP Code for the PO BOX must be provided and no street level information present.

Primary Address:		Ste:
City:	State:	Zip Code:
Phone:	Fax:	
Is this address used for "Telehealth services." ☐ Yes ☐ No	Is this address Handicap accessible? ☐ Yes ☐ No	

Additional Address:		Ste:
City:	State:	Zip Code:
Phone:	Fax:	
Is this address used for "Telehealth services." ☐ Yes ☐ No	Is this address Handicap accessible? ☐ Yes ☐ No	

Correspondence Address:		Ste:
City:	State:	Zip Code:
Phone:	Fax:	

Medical Record Address:		Ste:
City:	State:	Zip Code:
Phone:	Fax:	

Remittance Address:		Ste:
City:	State:	Zip Code:
Phone:	Fax:	

APPLICATION ATTESTATION: I, the undersigned, hereby attest that the above information is true and accurate to the best of my knowledge. By signing this application, I attest to not providing Telehealth only services and understand that I must maintain a physical practice location within the Health Plan's geographic service area to be considered for an in network participation.

Applicant Name (signature):	Date:

COLLABORATING PHYSICIAN ATTESTATION: I, the undersigned, hereby verify and attest that I am the collaborating physician for the above-named applicant. As required by applicable laws, I have satisfied myself as to the ability and competency of this applicant and that the functions that the applicant will carry out are performed under my collaboration and oversight.

Collaborating Physician Name (print):	Date:
Collaborating Physician Name (signature):	
Office Contact Name & Phone:	
Office Contact Email:	

Submit the completed application, diploma, licenses, malpractice (liability) insurance and W9 to us using one of the methods below. Psychoanalysts, LMSWs and LCATs must also include a copy of the collaborating physician's license.

Email: Provider.Enrollment@Excellus.com

Fax or Mail to the address below that is located closest to your primary office as:

For Rochester area: *165 Court Street, Rochester, NY 14647 / Fax Number: 1-800-676-6285*	*For CNY, Southern Tier, Utica/Watertown, PA & VT areas:* *333 Butternut Drive, Syracuse, NY 13214 / Fax Number: 1-800-676-6285*