



**BOSTON MEDICAL CENTER HEALTH NET PLAN
NON-PARTICIPATING PROVIDER ACTIVATION FORM**

You must fax this completed form and a copy of your W-9 to 617-897-0818. If you do not, this will cause a delay in the processing of your claims.

Date of Request	_____	Referral/Auth. #	_____
Requested By	_____	Department:	_____
Member Name	_____	BMCHP Member #:	_____
Member Plan	_____		

PROVIDER INFORMATION

**Please*

complete all applicable fields below. If the provider information is not complete, it will delay the processing of this request.

Entity: Practitioner Facility Group

Provider Name _____

Provider NPI # _____

Provider Title (i.e. MD, DMO, PA) _____

Group Name (if applicable) _____

Provider's SSN _____ License # _____

Provider's DOB _____ Specialty _____

E- Mail Address: _____ Gender _____

Your e-mail address is required to receive notification you that you may submit claims.

Primary Practice

Address Line 1 _____

Address Line 2 _____

City _____

State _____ Zip code _____

Office Phone _____ Office Contact _____

Office Fax _____

Billing Information

Billing Name _____

Address _____

Address Line 2 _____

City _____

State _____ Zip code _____

Billing Contact _____ Phone _____

TAX ID _____ Fax: _____

Comments (Add Below)

Please Attach Copy of W-9 Form

Non-contracted providers treating members of BMC HealthNet Plan must obtain pre-authorization prior to delivering services to Plan members. BMC HealthNet Plan pre-authorization forms can be found on the Provider Page of our website at www.bmchp.org. You may also contact the pre-authorization team by phone at 1-800-900-1451, Option 3. Failure to obtain prior authorization may result in a denial of your claim.