TRIPLE-S SALUD
BlueCross BlueShield of Puerto Rico

TRIPLE-S ADVANTAGE

Contract Change Form Network Management

Section A.1: PROVIDER INFORMATION REQUEST:

NPI: _____ **Name:** _____

Specialty1: _____ **Specialty2:** _____ **Specialty3:** _____

***Provider email:** _____ ***Provider Cellphone:** _____

Administrative use Only

Section A.2: CONTACT CURRENT INFORMATION:

***Contact Person:** _____

***Title Contact Person:** _____

***Email:** _____ ***Cellphone**_____, **Telephone:** _____**Ext.:**_____

***Mailing Address:** _____ **City:**_____ **St:**_____**Zip Code:** _____-_____

Section A.3: TYPE OF REQUEST:

☐Demographics Changes in contract Information ***(Only A.4, A.5, or A.6)***

☐Add a New Facility, Office or Location

☐Change of Individual to Corporation

☐Change of Ownership

☐Add a new Specialty: _____

☐New Group

☐Change of Specialty: _____

☐Exclusion (include letter)

☐Inclusion to Group *(proceed with SECTION B)*

☐ Add Line of Business (LOB)

☐ Add Services: _____

☐ Change of Corporation to Individual

☐ Change Tax ID (include letter)

☐ Change NPI:
Old NPI: _____
*New NPI: _____
***(Provider need complete Contract Request Form)**

☐ Red Selective: ☐ **Imaging** ☐ **Laboratory**

☐ Other: _____

Section A.4: LINE OF BUSINESS:

Which line(s) of business do you want to add to your contract? ☐ Triple –S (Commercial) ☐ Triple-S (VITAL) ☐ Triple-S (Advantage)

Indicate which line(s) of business you are currently active: ☐ Triple –S (Commercial) ☐ Triple-S (VITAL) ☐ Triple-S (Advantage)

Section A.5: MAILING ADDRESS: Please provide Information *(if apply)* * ☐New ☐Delete ☐Modify

Mailing Address: _____

City:_____ **St: Zip Code:** _____-_____**Cellphone Number:** (__)_____ **Fax Number**: (___)_____-_____

Email:_____

Section A.6: PHYSICAL ADDRESS: Please provide information *(if apply)* * ☐ New ☐ Delete ☐ Modify

Physical Address 1:_____ City: _____ St: _____ Zip Code:_____

Accept New Patients ☐Yes ☐No **Handicap Access**: ☐Yes ☐No **E-prescribing:** ☐Yes ☐No

Office Phone Number: ___-_____ **Fax number:** _____-_____ **Email:**_____

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Section A.7: OFFICE HOURS:

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
AM IN							
AM OUT							
PM IN							
PM Out							

Section B: FOR INDIVIDUALS ONLY:

***Provider Name**: _____ **NPI**: _____
Last Name(s) *Name* *Initial*

Medicaid Provider? ☐No ☐Yes, Please Include Number_____, *Medicaid Management Information System **(MMIS)**.* **Medicare Provider?** ☐No ☐Yes, Please Include Number_____,*Provider Transaction Access Number **(PTAN).***

***Corporation Name**: _____**Corporation NPI**: _____

Are you a**: ☐ CSP / PSC / PC or CRL/LLC ☐ INC ☐ CORP **Medicaid Provider?** ☐No ☐Yes, Please Include Number_____, *Medicaid Management Information System **(MMIS)**.* **Medicare Provider?** ☐No ☐Yes, Please Include Number_____,*Provider Transaction Access Number **(PTAN).

***Corporation Documents Included?** ☐No ☐Yes, check below all the documents

☐ Tax ID/ Patronal Social Security ☐NPI ☐Registry Certificate ☐Good Standing Certificate ☐Incorporation Certificate
☐ **Other:** Specify, _____

Are you part of any Group, IPA or PMG? ☐No ☐Yes; *If **yes**, please complete this section:*

Group Name: _____ **Group NPI:** _____

Are you a PCP? ☐No ☐Yes; *If **yes**, please complete this section:*

Group Name: _____ ***Group NPI:*** _____

*Are you certified by Department of Health for administer sedation or general anesthesia? *
☐ Yes (dentist Only) ☐ No ☐ N/A

Are you certified by Department of Health for Radiation license (X-Ray)?
(if apply: Dentist, Chiropractic, Optometry, Podiatry)
Yes: _____ No: _____ Specialty: _____ #License_____
Are you certified in telehealth or telemedicine?
Yes: _____(include certification) No:_____

Section C: FOR NON-INDIVIDUALS ONLY:

*Facility Name: * _____ NPI: _____

Specialty:** _____Medicaid Number:** ☐No ☐Yes, _____Please Provide Number **Medicaid Management Information System (MMIS).** ***Medicare Provider:** ☐No ☐Yes, _____Please Provider Number **Provider Transaction Access Number (PTAN) Are you certified in telehealth? Yes: ____(include certification) No:_____**

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***Type of provider**

- ☐ Ambulance
- ☐ Type I ☐Type II ☐Type III ☐Air
- ☐ **Ambulatory**
  - ☐ Facility ☐Surgical Clinic/Center ☐Chemotherapy
- ☐ **Blood Blank**
- ☐ **Dialysis Center**
- ☐ **DME**
  - ☐ **Implants**
  - ☐ Orthopedic ☐Cardiovascular ☐Mesh
- ☐ **Emergency Room / Urgent Care Facility**
  - *24 hours availability? ☐ Yes ☐ No, if no specify
  - ☐ X-Ray ☐Laboratory* _____

  ***Include evidence of registration to share results.**
- ☐ **Home Health Agency**
- ☐ **Home Infusion**
- ☐ **Hospice**
- ☐ **Hospital**
- ☐ **Imaging Center**
  - ☐ Advanced Imaging (**Hitech Images -** MRI/MRA, CT, PET, Nuclear Medicine, Mammography, Ultrasound)
  - ☐ Other: Specify: _____
- ☐ **Infusion Center**
- ☐ **Laboratory**
  - ☐ Clinical ☐Genetics ☐Special Procedures

  ***Include evidence of registration to share results.**
- ☐ **Non-Emergency Transportation**
- ☐ **Preventive Clinic**
- ☐ **Prosthesis & Orthosis Supplier**
- ☐ **Skilled Nursing Facility**
- ☐ **Specialized Pharmacy**
- ☐ **Vaccination Center**
- ☐ **Vision Center**
- ☐ **Wound Care**
- ☐ **Alternative Medicine**
- ☐ **Bariatric Excellence Center**
- ☐ **Da Vinci (Robotic Surgery)**

If **Hospital:** List Other NPI's or subparts are attached to your facility:

NPI:	Specialty:
_____	_____
_____	_____

Section D: Authorization:

Authorized Signature: _____
(if not a physician)

Print Name: _____ **Date:** _____

Title of Authorized: _____

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Contract Change Form Network Management

Please SEND this form to contrataciones@ssspr.com or our mailing address:
Network Management Contracting Department
Po Box 363628 San Juan, PR 00936-3628

Section A.1: PROVIDER INFORMATION REQUEST

1. This Section the provider needs to provide the correct information: NPI, Legal Name (individual, Corp, Group, etc.).
2. Specialties provider
3. Provider Contact: email and cellphone.

Section A.2: CONTACT CURRENT INFORMATION

4. This section MUST be completed by ALL requestors. The information in this section may be used by Triple-S if any additional information is required.
5. **Contact Person** Full name of contact person.
6. **Title Contact Person**
7. **Email** Include contact person's e-mail address to which evaluation result will be sent.
8. **Telephone(s)** Contact person's telephone numbers and extension numbers (if apply)
9. **Cellphone Contact person's cell phone numbers**
10. **Mailing Address** Include additional address where the provider will receive the correspondence.

Section A.3: TYPE OF REQUEST

1. Mark with an "X' the type of request, as applicable. If the following areas was selected, please provide all address in Section A.4:
   - Demographics Changes in contract information
   - Add a New Facility or office
   - Change of Individual to corporation
   - Add a new Specialty.
   - New Group
   - Change of Specialty
   - Exclusion (include letter)
   - Inclusion to Group
   - Add Line of business (LOB)
   - Add Service
   - Change Tax id (include letter)
   - Change NPI (include Old and New NPI)
   - Other:

Section A.4: LINE OF BUSINESS

1. **Which line(s) of business do you want to add to your contract?** Mark with an "X" all lines of business for which the provider wants to be considered (do not mark lines of business for which the provider is already active)
2. **Indicate which line(s) of business you are currently active:** Mark with an "X" all lines of business for which the provider has been already contracted. (Lines of business marked here should not be marked in previous question.)

Section A.5: MAILING ADDRESS

1. Mark with an "X' Mark with an "X' to identify address is: New, Delete or Modify
2. **Mailing Address:** Include the mailing address where the provider has an office or facility.
3. **Cellphone** provider's cellphone numbers
4. **Fax** provider's fax number
5. **Email** Include provider's e-mail address

Section A.6: PHYSICAL ADDRESS

1. Mark with an "X' to identify address is: New, Delete or Modify
2. **Physical Address:** Include the physical address where the provider has an office or facility where medical services are offered.
3. **Accept New Patients? Yes or No**
4. **Handicap Access? Yes or No**
5. **E-prescribing? Yes or No**
6. **Telephone** Include office phone number
7. **Fax** provider's fax number
8. **Email** Include office e-mail address

Section A.7: OFICCE HOURS

1.Provide the hours in each day.

Section B: INDIVIDUALPROVIDER Section

1. This section is for Individual providers ONLY (Physicians and other Health Care Professionals)
2. Individual Providers MUST complete ALL data elements in this section.
3. **Provider Name** Last Names (paternal and maternal), First Name and Middle Name Initial
4. **NPI** Indicate NPI for which the provider wants a contract. It the provider has a Corporation NPI (marked in the previous question), include Provider's individual NPI.
5. **Specialty** Indicate medical specialty.
6. **Medicaid Provider?** Respond YES or NO, as applicable and include Number **Medicaid Management Information System (MMIS).**

7. **Medicare Provider?** Respond YES or NO, as applicable and include Number **Provider Transaction Access Number (PTAN).**
8. **Are you a CSP/PSC or CP/PC or CRL/LLC or Other**
    a. Mark with an "X" the corresponding corporation type where
        i. CSP/PSC – Corporación de Servicios Profesionales / Professional Service Corporation
        ii. CP/PC – Corporación Profesional / Professional Corporation
        iii. CRL/LLC – Corporación de Responsabilidad Limitada / Limited Liability Corporation
        iv. CORP/INC Corporation incorporated/Corporación/Incorporación
    b. **Corporation Name If** a Corporation, include Name of Corporation
    c. **Corporation NPI** Indicate NPI of the corporation
    d. **Corporation Documents** Included the required documents for the corporation. All the documents must be valid.
    e. **Provider is part of any Group, IPA or PMG Yes or No if yes, completed Group name and NPI Number.**
    f. **Provider is PCP Yes or No if yes, completed Group name and NPI Number.**
    g. Provider is certified by Department of Health for administer sedation or general anesthesia? respond Yes, No or N/A (dentist only)
    h. Provider certified by Department of Health for Radiation license (X-Ray)? if apply only specialties: Dentist, Chiropractic, Optometry, Podiatry.
    i. Provider certified in telehealth or telemedicine. Respond Yes or No if yes, include certification.

Section C: NON-INDIVIDUAL PROVIDERS Section

1. This section is for providers who are NOT individuals, such as but not limited to, Imaging Centers, Hospitals, Emergency Room, DME, Ambulatory Chemotherapy or Surgical Centers, Laboratories, etc.
2. . If one of the following is marked, the information shown below MUST also be provided:
    a. **HOSPITAL** List of ALL NPIs of subparts of the facility whose services are wanted to be considered for contracting.
    b. **CLINICAL LABORATORY** Must respond a YES or NO to the question **Do you have the Clinical Chemistry Equipment for each individual location?**
    c. **Laboratories: Include evidence of registration to share results.**
    d. **EMERGENCY ROOM** Must respond a YES or NO to the question **is the facility available 24 hours?**
    e. **IMAGING CENTER** Mark with an "X" as applicable, the following image types
        i. **Hi-tech Images** (CT, MRI, PET, Nuclear Medicine)

    Other Images Specify what type of images will be rendered.