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:** _____

Section A.2: CONTACT CURRENT INFORMATION:

***Contact Person:** _____

***Email:** _____ ***Telephone(s)** _____

***Mailing Address:** _____ **City:**_____ **St:**_____

Zip Code: _____-_____

Section A.3: TYPE OF REQUEST:

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

☐ Add a New Facility or Office

☐ Change of Individual to Corporation

☐ Change of Ownership

☐ Add a new Specialty

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

☐ Add LOB

☐ Add Services

☐ Change of Corporation to Individual

☐ Change of NPI or Tax ID

☐ Change of Specialty

Section A.4: LINE OF BUSINESS:

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

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

Section A.5: CURRENT ADDRESS: Please provide Information *(if apply)* *

☐ **Mailing** ☐ **Office Location** ***Name of PGM/IPA (if apply):** _____

***Address 1**: _____ **City:**_____ **St:**_____

Zip Code: _____-_____

Line of Business: ☐ Triple –S Salud (Commercial / PSG) ☐ Triple-S (Advantage)

Phone Number: (____)_____-_____ **Fax Number:** (____)_____-_____

Email: _____ **Website:** _____

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

☐ **Mailing** ☐ **Office Location** ***Name of PGM/IPA (if apply):** _____

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***Address 1**: _____ **City:**_____ **St:**_____

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

Line of Business: ☐ Triple –S Salud (Commercial / PSG) ☐ Triple-S (Advantage) **Phone Number:** (____)_____-_____

Fax Number: (____)_____-_____**Email:** _____ **Website:** _____

Section A.7: OFFICE HOURS: Line of Business: ☐ Triple –S Salud ☐ Triple-S (Advantage)

	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*

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

***Are you a**: ☐ CSP / PSC / PC or CRL / LLC ***Medicare Provider?** ☐No ☐Yes, _____ Please Include Number

***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, _____ **Corporation Documents Included?** ☐ Yes ☐ No

Are you part of any Group? ☐ 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:** _____

***Dentist Only:** ☐ **N/A**

Are you certified by Department of Health for administer sedation or general anesthesia?

☐ Yes ☐ No

Section C: FOR NON-INDIVIDUALS ONLY:

***Facility Name:** _____ *NPI: _____

***Specialty:** _____ ***Medicare Provider:** ☐No ☐Yes, _____ Please Provide Number

***Medicaid Provider:** ☐No ☐Yes, _____ Please Provide Number

Contract Change Form Network Management

***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 _____
- ☐ **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
- ☐ **Non-Emergency Transportation**
- ☐ **Preventive Clinic**
- ☐ **Prosthesis & Orthosis Supplier**
- ☐ **Skilled Nursing Facility**
- ☐ **Specialized Pharmacy**
- ☐ **Vaccination Center**
- ☐ **Vision Center**
- ☐ **Wound Care**

*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: _____

Please **SEND** this form to contrataciones@ssspr.com or our mailing address:

Network Management
Contracting Department
Po Box 363628
San Juan, PR 00936-3628

TRIPLE-S SALUD
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TRIPLE-S ADVANTAGE

Contract Change Form Network Management

Section A.1: PROVIDER INFORMATION REQUEST

1. This Section the provider need to provide the correct information: NPI, Legal Name (individual, Corp, Group, etc.).

Section A.2: CONTACT CURRENT INFORMATION

2. This section MUST be completed by ALL requestors. The information is in this section may be used by Triple-S if any additional information is required.
3. **Contact Person** Full name of contact person.
4. **Email** Include contact person's e-mail address to which evaluation result will be sent.
5. **Telephone(s)** Contact person's telephone numbers
6. **Mailing Address** Include 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
   - Change of Ownership
   - Inclusion to Group (proceed with Section B)
   - Change of Individual to Corporation
   - Add New Specialty
   - Change of Corporation to Individual
   - Change of NPI or Tax ID
   - Change Specialty
   - Add a New Facility or Office

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: CURRENT ADDRESS OFFICE LOCATION

1. Mark with an "X' the type of address
2. **Current Address:** Include the current address where the provider has an office or facility.
3. Mark with an "X" the line of business of this address
4. **Telephone(s)** provider's telephone numbers
5. **Fax** provider's fax number
6. **Email** Include provider's e-mail address
7. **Website** Include provider's e-mail address

Section A.6: NEW ADDRESS

1. Mark with an "X' the type of address
2. **New Address:** Include the new address where the provider has an office or facility where medical services are offered.
3. Mark with an "X" the line of business of this address
4. **Telephone(s)** provider's telephone numbers
5. **Fax** provider's fax number
6. **Email** Include provider's e-mail address
7. **Website** Include provider's e-mail address

Section A.7: OFICCE HOURS

1. Mark with an "X" all lines of business for the office hours
2. Provide the hours in each day

Section B: INDIVIDUAL PROVIDERS 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. **Medicare Provider?** Respond YES or NO, as applicable.
7. **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
   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.

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. Non-Individual Providers MUST complete ALL data elements in this section.
3. **Facility Name** Include complete name of Facility, including the Corporation type (CSP/PSC, CP/PC, CRL/LLC) when applicable
4. **NPI** Include Provider's NPI
5. **Specialty** Identify type of provider or specialty (Hospital, Ambulance, Ambulatory Chemotherapy, Clinical Laboratory (Free Standing or Hospital Based), etc.
6. **Medicare Provider?** Respond YES or NO, as applicable
7. **Provider Type**: Mark with an "X" the type of provider, as applicable. 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. **EMERGENCY ROOM** Must respond a YES or NO to the question **is the facility available 24 hours?**
   d. **IMAGING CENTER** Mark with an "X" as applicable, the following image types
      i. **Hi-tech Images** (CT, MRI, PET, Nuclear Medicine)
      ii. **Other Images** Specify what type of images will be rendered

Incomplete forms may not be considered for evaluation