

CHAPTER 3: PROVIDER NETWORK PARTICIPATION

UNIT 1: NETWORK PARTICIPATION OVERVIEW

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[What Is My Service Area?](#)

The *Highmark Provider Manual* contains information, policies, and procedures that apply to Highmark network participating providers in Pennsylvania, Delaware, West Virginia, and contiguous counties. The symbols below are used in the manual to identify information that is specific to one state. In some instances, information may be designated as applicable to two states only. **Where no symbol is present, the information is relevant to all states.**



The PA ONLY symbol indicates the information in the section is applicable to providers participating in Highmark networks in Pennsylvania and contiguous counties.



The DE ONLY symbol indicates the information in the section is applicable to providers participating in Highmark networks in Delaware and contiguous counties.



The WV ONLY symbol indicates the information in the section is applicable to providers participating in Highmark networks in West Virginia and contiguous counties.

3.1 INTRODUCTION TO NETWORK PARTICIPATION

Overview

Highmark pays claims for services performed by licensed, eligible health care providers. Eligible providers may sign an agreement to participate in one or more of Highmark's provider networks. Providers who choose not to participate in Highmark's networks must register with Highmark prior to submitting claims for covered services.

As a participant in any of Highmark's networks, providers agree to provide services to Highmark members according to the terms of their agreement, the regulations that outline their obligations to Highmark members, and any relevant administrative requirements. Although they do not sign an agreement with Highmark, non-network providers are required to accurately report services performed and fees charged.

All providers who submit claims to Highmark must obtain an individual National Provider Identifier (NPI) number. Highmark will only make payments for eligible services rendered by a provider with a valid NPI. To learn more about obtaining an NPI, please see the section in this unit titled **National Provider Identifier (NPI)**.

Non-discrimination policy

In selecting and credentialing providers for the associate networks, Highmark does not discriminate in terms of participation or reimbursement against any health care professional who is acting within the scope of their license or certification. In addition, Highmark does not discriminate against professionals who serve high-risk populations or who specialize in the treatment of costly conditions. If Highmark declines to include a provider in its networks, Highmark will furnish written notice of the reason for its decision to the affected provider.

Compliance with the Mental Health Parity and Addiction Equity Act

In compliance with the Mental Health Parity and Addiction Equity Act of 2008 ("MHPAEA"), Highmark applies the same network admission and provider credentialing standards to all providers in comparable manner regardless of whether the provider renders medical services, behavioral health services or substance abuse treatment services. If you have questions about MHPAEA, you can email your questions to HPMeditor@highmark.com.

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3.1 INTRODUCTION TO NETWORK PARTICIPATION, Continued

Eligible organizational providers (facility and ancillary)

Highmark holds contracts with organizational providers (facility and ancillary) and credentials them in order to ensure they are in good standing with all regulatory and accrediting bodies.

- Eligible facility type providers include, but are not limited to, acute care hospitals, psychiatric facilities, substance abuse treatment centers, skilled nursing facilities, ambulatory surgical centers, hospice, and home health.
- Eligible ancillary providers include freestanding and facility-based providers in the specialties including, but not limited to, independent laboratories, durable medical equipment, home infusion, and ambulance.

For more information specifically on organizational provider participation, please see the manual's [Chapter 3.4: Organizational Provider Participation](#).

Who is an eligible professional provider?

Eligible professional providers include:

- Doctors of Medicine (MD)
- Doctors of Osteopathy (DO)
- Doctors of Dentistry (DDS/DMD)
- Doctors of Podiatry (DPM)
- Doctors of Optometry (OD)
- Doctors of Chiropractic (DC)
- Nurse midwives
- Licensed physical therapist
- Licensed psychologist
- Certain certified registered nurses
- Licensed audiologist
- Licensed speech-language pathologist
- Licensed clinical social workers
- Licensed occupational therapists
- Licensed marriage and family therapists
- Licensed professional counselors
- Licensed dietitian – nutritionist

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Additional providers eligible in WV



Highmark West Virginia also contracts with the following provider types for networks and/or programs as indicated:

- Acupuncturists -- for Federal Employee Program (FEP) members only
- Massage Therapists – for commercial networks only
- Certain diabetic educators – for all provider networks*
- Licensed Physician Assistants – for all provider networks*

*Including Medicare Advantage

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3.1 INTRODUCTION TO NETWORK PARTICIPATION, Continued

Physician assistants & acupuncturists



Practitioners who are not eligible to contract with Highmark to participate in Highmark's networks in Pennsylvania and Delaware may be eligible to provide services for certain government programs only (e.g., FEP and Medicare Advantage).

Acupuncturists: Although acupuncturists are not eligible to contract with Highmark for our commercial and Medicare Advantage networks in Pennsylvania and Delaware, they are fully credentialed and contracted to provide services to FEP members only.

Physician Assistants (PAs): In Pennsylvania and Delaware, Physician Assistants are not eligible to participate in Highmark's commercial networks as independent practitioners; the services they perform are recognized only when they are employed by and acting under the personal supervision of a physician. However, Physician Assistants are eligible to contract with Highmark to provide services to Medicare Advantage members in Pennsylvania.

Practitioners who may serve as PCPs

A physician (MD or DO) who is a family practitioner, general practitioner, internal medicine practitioner, or pediatrician is entitled to participate as a primary care physician (PCP). The physician must complete the credentialing process.

In addition, certified registered nurse practitioners (CRNPs) have the opportunity to offer their clinical expertise as a primary care CRNP to Highmark members. Qualified CRNPs must complete a credentialing application and meet credentialing requirements to receive designation as a primary care CRNP with Highmark. CRNPs cannot be dual credentialed and serve as both a CRNP specialist and a PCP within the same group practice. However, a CRNP can be dual credentialed for different group practices, serving as a CRNP specialist in one group, and serving as a PCP in another group practice.

In West Virginia only, physician assistants (PAs) may also participate as PCPs.

Practitioner availability monitoring

Since Highmark requires members to utilize a designated practitioner network, Highmark must ensure that there are adequate numbers and geographic distribution of primary care, behavioral health, and specialty care practitioners to meet member needs. Highmark monitors practitioner availability annually against its standards and initiates action, as needed, to improve member access to covered services.

Practitioner availability monitoring is completed for primary care practitioners, high volume specialty care practitioners, and behavioral health practitioner types. All behavioral health practitioner types (not just high volume types) are assessed on an annual basis.

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3.1 INTRODUCTION TO NETWORK PARTICIPATION, Continued

General conditions of participation

In order to participate in Highmark's networks, a provider must:

- Execute the appropriate network participation agreement(s), which include the terms of payment, and complete fully any required application or information forms;
- Abide by the terms and conditions of such agreement(s), including any amendments;
- Satisfy and remain in compliance with applicable Highmark credentialing and recredentialing standards;
- Cooperate and comply with Highmark's health services management programs, including but not limited to: precertification, prior authorization, care and case management, disease management, clinical quality improvement, and other programs and initiatives that maybe adopted;
- Provide timely written responses to complaints or clinical quality issues upon request from Highmark;
- Follow Highmark's appeals processes and other dispute resolution mechanisms; and
- Adhere to Highmark's billing, claims submission, and other administrative guidelines and requirements, including this *Highmark Provider Manual*.

Open/closed networks

Highmark accepts applications in any of its networks, with only a limited area closed to new practitioners of specific provider types. Highmark reserves the right, however, to close one or more of its network to specific types of providers or to additional service locations if:

- Highmark determines that it has contracted with a sufficient number and distribution of providers to serve its members adequately; or
- Highmark determines that closing the network would otherwise be in the best interests of its members, the company, and network providers.

If Highmark elects in the future to close a network, notice of such policy will be communicated.

Mutual roles and obligations for network participating providers and Highmark

As a participant in any of Highmark's networks, providers agree to a set of regulations that outline their obligations to Highmark members. Highmark has obligations to its network participants as well. The agreements and regulations that providers execute when joining the network contain the mutual obligations.

Key contractual provisions include:

- Network providers will accept the network allowance as payment-in-full for covered services, less any applicable copayments, deductibles, and/or coinsurance.

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3.1 INTRODUCTION TO NETWORK PARTICIPATION, Continued

Mutual roles and obligations for network participating providers and Highmark
(continued)

- Highmark will make payment directly to network providers and will notify the member of any responsibility they may have (such as non-covered services, coinsurance, and/or deductibles).
- Network providers will handle basic claims filing paperwork for the member.
- Highmark will encourage members to obtain health care services from network providers which could increase the provider's patient base.
- Network providers will recommend their patients see other network providers when necessary.
- Providers participating in any of Highmark's professional provider networks are eligible to become actively involved with Highmark as corporate professional members and as members of the company's various professional committees and advisory councils.

Equal access and non-discrimination in treatment of members

In addition to requirements contained in your provider agreement and in any other applicable administrative requirements, network providers agree to requirements of equal access and non-discrimination of Highmark members within this manual. Complaints will be investigated as appropriate and referred to the Credentialing Committee for appropriate action.

Providers will provide members with equal access at all times to provider services. Providers agree not to discriminate in the treatment of Highmark members, or in the quality of services delivered, on the basis of place of residence, health status, race, color, ethnicity, national origin, religion, sex, age, mental or physical disability or medical condition, sexual orientation, claims experience, medical history, evidence of insurability (including conditions arising out of acts of domestic violence), genetic information, or source of payment. Further, providers shall not deny, limit, discriminate or condition the furnishing of provider services to members based on their known or believed relationship or association with an individual or individuals of a particular race, color, national origin, sex, age, or disability.

Meeting cultural and linguistic needs

Network providers must ensure that services, both clinical and non-clinical, can meet the cultural and linguistic needs of all members, including those with limited English proficiency, disabilities, reading skills, diverse cultural and ethnic backgrounds, sexual orientation, and the homeless; and are responsive to member needs and preferences.

Highmark may be able to assist a provider to locate translator or interpreter services for members who are non-English speaking or hearing impaired. The provider or member should call the Highmark Member Service telephone number on the back of the member's ID card.

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3.1 INTRODUCTION TO NETWORK PARTICIPATION, Continued

**Non-retaliation
for exercise of
rights and
remedies**

Providers are encouraged to become knowledgeable of the rights and remedies available to them under their agreement(s) with Highmark, this *Highmark Provider Manual*, and other administrative policies and procedures.

It is our policy to treat providers courteously, professionally, and fairly in all circumstances. Providers can be assured that they will not be subject to discriminatory treatment or retaliation in any form of exercising rights and remedies afforded them pursuant to their agreements with Highmark.

OBSOLETE

3.1 PROMISe ID ENROLLMENT REQUIRED FOR PENNSYLVANIA CHIP

Background



Effective January 1, 2018, the Pennsylvania Department of Human Services (DHS) implemented the Affordable Care Act (ACA) Provider Enrollment and Screening provisions that require all providers who render, order, refer, or prescribe items or services to Children's Health Insurance Program (CHIP) enrollees to have a valid PROMISe™ ID.

Providers who provide services to CHIP enrollees must complete a Provider Reimbursement and Operations Management Information System (PROMISe) enrollment application for their provider type for each service location where they see CHIP enrollees. Once enrolled, the provider is issued a PROMISe ID, which is required to provide services to CHIP enrollees and receive reimbursement.

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Enrollment guidelines



The DHS PROMISe ID enrollment requirements apply to all providers who provide services to CHIP enrollees. The Pennsylvania Office of CHIP requires every provider servicing CHIP enrollees to have a PROMISe ID assignment for each service location and for each provider NPI (includes practitioner, group, vendor, and billing NPI).

To enroll, you must complete an enrollment application appropriate for your provider type and for each service location (provider's physical address). You need to enroll for each location and NPI to obtain a PROMISe ID to service CHIP enrollees covered under the Pennsylvania CHIP program.

If you are already enrolled in PROMISe ID for the Pennsylvania Medical Assistance Program (also called "Medicaid"), you do not need to enroll again for CHIP. However, if you are enrolled with another state's Medicaid or CHIP program or are enrolled in Medicare, you must enroll with Pennsylvania's DHS to service CHIP enrollees in Pennsylvania.

Note: Most providers are not required to pay the application fee, which typically applies to larger facilities.

[Why blue italics?](#)

CHIP PROMISe ID enrollment



Providers can complete a PROMISe ID application to enroll in CHIP and/or Pennsylvania Medical Assistance. If completing an application for CHIP only, you would not be enrolled as a Medical Assistance provider and you would not be required to service Pennsylvania Medical Assistance beneficiaries.

CHIP PROMISe ID enrollment information and applications, both electronic and printable PDF versions, are available on the DHS website at:

<http://www.dhs.pa.gov/provider/promise/enrollmentinformation/CHIPProEnrollInfo/index.htm>

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3.1 PROMISe ID ENROLLMENT REQUIRED FOR PENNSYLVANIA CHIP,

Continued

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Add your PROMISe ID to Highmark's provider file



Once you obtain your PROMISe ID, you must add it to Highmark's provider file. Highmark simplifies this process by providing an electronic form that lets you easily add your PROMISe ID to your information in our provider database.

You can click on the link provided here to complete and submit the **PROMISe ID Update Request** form, which will update our files:

https://highmark.co1.qualtrics.com/jfe/form/SV_8AIDgu7WFTfrIAN

This form is also available on the Provider Resource Center—select **FORMS** from the main menu on the left, and then **Provider Information Management Forms**. The **PROMISe ID Update Request** form is located in the bulleted list under the **ELECTRONIC FORMS** category.

Avoid claim denials



PROMISe ID enrollment is required to receive payment for CHIP enrollee claims. Highmark will deny claims from providers who have not completed PROMISe ID enrollment with Pennsylvania's DHS.

[Why blue italics?](#)

FOR MORE INFORMATION

For more information about the CHIP program in Pennsylvania, please see the Highmark Provider Manual's **Chapter 2.3: Other Government Programs**.

OBSOLETE

3.1 NETWORK COMPLIANCE

Policy	<p>Providers participating in Highmark’s provider networks must comply with the terms and conditions of their provider agreement(s) and meet acceptable standards for quality of clinical care, resource utilization, and administrative compliance in order to ensure that the networks operate in an effective and efficient manner. This also ensures that members receive high quality, medically appropriate, and cost-effective care.</p> <p>Providers who are not compliant are subject to the network corrective action policy providing for corrective action, sanctioning, suspension, and termination of providers arising from non-compliance with contractual obligations or failure to meet acceptable standards of clinical care, resource utilization, and/or administrative compliance.</p>
Categories of non-compliance	<p>Non-compliance can be divided into three categories:</p> <ol style="list-style-type: none"> 1. Quality of care concerns 2. Unacceptable resource utilization 3. Administrative non-compliance
Quality of care concerns	<p>A quality of care concern arises when an episode of care deviates from accepted medical standards. The occurrence of an adverse outcome does not, in and of itself, indicate a breach of accepted medical standards and/or warrant action.</p>
Examples of quality of care concerns	<p>Examples of quality of care concerns include, but are not limited to:</p> <ul style="list-style-type: none"> • Actions or omissions that result or may result in an adverse effect on a patient’s well-being • Delayed services/referrals • Missed diagnoses • Medication errors • Delayed diagnosis/treatment • Unexpected operative complications • Invasive procedure complications • Inappropriate procedures • Unanticipated, unexplainable death • Actions requiring a report to the National Practitioner Data Bank (NPDB) or other adverse actions

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3.1 NETWORK COMPLIANCE, Continued

Unacceptable resource utilization

Unacceptable resource utilization is defined as a pattern of utilization that is at variance with recognized standards of clinical practice or with specialty-specific aggregated data.

Examples of unacceptable resource utilization

Examples of patterns of unacceptable resource utilization include but are not limited to:

- Inappropriate or unnecessary admissions
 - Inappropriate utilization of emergency services
 - Inappropriate or unnecessary inpatient hospital stay days
 - Patterns of inappropriate utilization of outpatient surgery
 - Patterns of inappropriate PCP encounters per member per year
 - Patterns of inappropriate utilization of referrals
 - Under-utilization (i.e., withholding) of necessary and appropriate medical services
-

Administrative non-compliance

Administrative non-compliance is defined as behavior that does not comply with applicable laws, regulations, or Highmark policies or procedures, or that is detrimental to the successful functioning of Highmark as a health plan or to its members' rights or benefits under their plan.

Examples of administrative non-compliance

Examples of administrative non-compliance include but are not limited to:

- Direct or unauthorized billing for services
 - Balance billing a member for services
 - Failure to cooperate/comply with Highmark's administrative quality improvement, utilization review, credentialing, member service, reimbursement, and other procedures
 - Conduct that is unprofessional toward members, family members, and/or staff of Highmark
 - Failure to comply with any contractual obligation
 - Failure to comply with policies and procedures of Highmark
 - Failure to comply with or violation of state or federal laws or regulations
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3.1 NETWORK COMPLIANCE, Continued

Use of information and data for quality improvement and transparency and compliance requirements

Providers acknowledge and will cooperate with Highmark's quality improvement and transparency programs and initiatives, which include, but are not limited to, programs developed to support Highmark's member and provider initiatives, and satisfy the compliance requirements of the National Committee for Quality Assurance (NCQA), other accreditation entities, and any applicable regulatory body (collectively, "Quality Initiatives").

In connection with Quality Initiatives, Highmark may use the Provider Data for such purposes, including but not limited, as follows:

- (a) Utilize, publish, disclose, and display any information and data related directly or indirectly to the Provider's delivery of health care services, such as, but not limited to, performance or practice data, information relating to Provider's costs, charges, payment rates and quality, utilization, outcome and other data ("Provider Data");
- (b) Disclose the Provider Data to Highmark's contracted vendors and agents to assist in the review, analysis, and reporting of the Provider Data;
- (c) Report the Provider Data to other providers to assist such providers in the management of care costs, quality outcomes, and other efficiencies;
- (d) Report the Provider Data to Members and customers (including third parties who supply information and analysis services to group customers); and
- (e) Use the Provider Data to support Provider's participation in certain benefit value levels (such as network tiers).

Providers acknowledge and agree that any Provider Data is proprietary to Highmark, a highly confidential trade secret of Highmark, and is entitled to protection as such. In the event that a Provider receives any Provider Data (which may be the Provider's own Provider Data or the Provider Data of a provider other than the Provider), the Provider agrees to maintain the Provider Data as confidential and to use it for the purpose or purposes for which the Provider Data was provided by Highmark or its contractor or agent and agrees to not publish or publicly share the Provider Data, except as expressly permitted by Highmark in writing.

Without limiting the foregoing, any provisions in the Provider's participating agreement or Administrative Requirements that address the confidentiality of information and data, such as the Provider Data, shall remain in full force and effect and such provisions shall govern the Provider Data in addition to this section of Chapter 3.1 of the Highmark Provider Manual.

3.1 ELECTRONIC TRANSACTION REQUIREMENTS

Overview

In support of the Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009, Highmark has taken steps to eliminate paper transactions with our contracted providers. Because of the inherent speed and cost-effectiveness, electronic and online communications are integral in today's business world and Highmark requires that all network providers participate in electronic programs sponsored or utilized by Highmark now or in the future.

Enrollment in NaviNet, EFT, & paperless EOBs/remittances required for all participating providers

All Highmark network participating providers are required to enroll in NaviNet®, Electronic Funds Transfer (EFT), and paperless Explanation of Benefits (EOB) statements and Remittance Advices. All new assignment accounts must sign up for NaviNet and also enroll in EFT and paperless EOBs/remittances.

NaviNet is an easy online solution linking physician offices and facilities with Highmark and other health plans. NaviNet integrates all insurer-provider transactions into one system (e.g., eligibility and benefit inquiries, claim status inquiries, claim submission, authorization requests, etc.). This service is available at no cost to Highmark network participating providers.

Participating providers are also required to enroll to receive electronic funds transfers and paperless EOB statements/remittances.

- EFT is a secure process that directs Highmark claim payments to the provider's checking or savings account as directed by your office. Payments are typically in the designated bank account by Wednesday of each week.
- Paperless EOB statements and remittances reduce the amount of paper flowing into the provider's office. They are available for viewing on Monday morning via NaviNet --which is two days earlier than receiving them by mail.

How to sign up for NaviNet

To sign up for NaviNet, you can call Highmark's Provider Service Center or go to navinet.net, and then click on the **PROVIDERS: SIGN UP FOR NAVINET** button.



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3.1 ELECTRONIC TRANSACTION REQUIREMENTS, Continued

Enrolling in EFT and paperless EOBs & remittances

After becoming NaviNet-enabled, providers must also enroll in electronic funds transfer (EFT) and paperless EOB statements and remittances. This is done through the **EFT Attestation and Registration** transaction on NaviNet. To use this transaction, the provider's NaviNet Security Officer must enable the function for the EFT Responsible Party. Your NaviNet Security Officer is an employee of your practice or health system who has been assigned to serve as the primary contact with NaviNet.

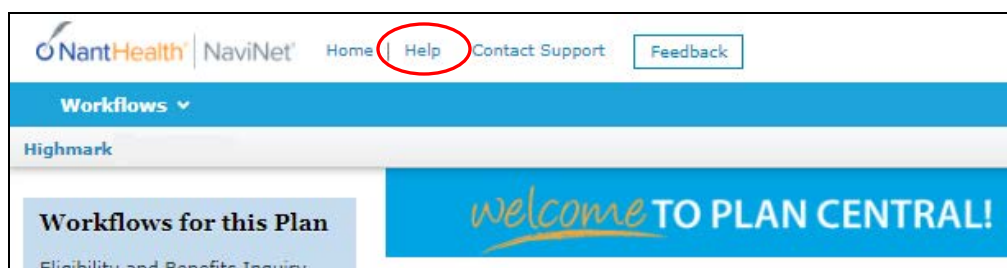
The EFT Attestation and Registration transaction allows the person who is designated as the provider's "EFT Responsible Party" to electronically attest, register, and/or maintain banking information on behalf of the practice. Once you are enrolled and start receiving EFT payments, you will no longer receive paper EOB statements or remittances. You can view your electronic EOBs and remittances via NaviNet. To access EFT payment detail and EOBs and remittances, select the **AR Management** transaction from the Highmark Plan Central menu.

Helpful instructions for using the EFT Attestation and Registration transaction are available on the Provider Resource Center in both video and PDF formats.

- Pennsylvania: Select **PROVIDER TRAINING** from the main menu, and then **Provider Training** from the submenu. Please see the **NAVINET SELF SERVICE GUIDES** category.
- Delaware and West Virginia: Select **EDUCATION/MANUALS** from the main menu, and then **Provider Training**. Please see the **NAVINET SELF SERVICE GUIDES** category.

The [EFT Attestation and Registration Guide](#), a helpful, printable PDF document, is available in that location.

In addition, NaviNet provides support for available transactions – just click on **Help** at the top of Highmark Plan Central to access NaviNet Support. Select the Highmark Health Plan for your location, and then click **Go**. You'll find a User Guide for EFT Attestation and Registration under the **Office & Provider Management** heading.



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3.1 ELECTRONIC TRANSACTION REQUIREMENTS, Continued

**Health
information
exchange
programs**

Network providers are also required to participate in any Highmark, Highmark-sponsored, and/or Highmark designated state or community sponsored health information exchange program, which supports and/or facilitates the availability and exchange of claims-based information and clinical information for the treatment and ongoing management of Highmark members and/or other patients of network providers.

Any requirements relating to participation in such health information exchange program shall be provided through Highmark communications and/or administrative requirements in advance of such participation requirement and shall be binding on network providers and Highmark.

OBSOLETE

3.1 PROVIDER NETWORKS

Overview of Pennsylvania networks



This section provides brief descriptions of Highmark's professional provider networks in the state of Pennsylvania and contiguous counties.

Commercial networks in Pennsylvania include:

- Participating Provider Network
- Premier Blue Shield statewide provider network
- Keystone Health Plan West (KHPW) managed care network (Western Region only)
- Community Blue select network

Medicare Advantage networks in Pennsylvania:

- Freedom Blue PPO
- Community Blue Medicare PPO/Plus PPO
- Medicare Advantage HMO (Western Region only)
- Community Blue Medicare HMO

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Participating Provider Network



Highmark has agreements with thousands of Participating Providers representing every major specialty. Any eligible professional provider licensed to practice in Pennsylvania may apply for participating status by completing the *Participating Provider Agreement With Highmark Blue Shield*.

This is not a credentialed network—a professional provider's admission to the network is based solely on Pennsylvania licensure and the execution of a Participating Provider Agreement. This network services our traditional Highmark Blue Shield programs, including traditional BlueCard® as well as BlueCard Point of Service (POS) and Health Maintenance Organization (HMO) programs.

Premier Blue Shield Network



The Premier Blue Shield Network is Highmark's statewide selectively contracted preferred provider network in Pennsylvania. Any eligible facility and professional provider licensed to practice medicine in Pennsylvania may apply for the Premier Blue Shield network. You must meet the network's credentialing criteria to be accepted into the network.

Because Premier Blue Shield supports managed care products, Highmark must ensure the network complies with the regulations of the Pennsylvania Department of Health governing Managed Care Organizations (28 PA Code, Chapter 9). These regulations require that we ensure network providers meet certain standards. As a result, Highmark staff conducts site visits and medical record reviews of primary care practitioners, obstetricians/gynecologists, high volume behavioral health provider offices, and facilities.

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3.1 PROVIDER NETWORKS, Continued

Premier Blue Shield Network (continued)



This network supports a variety of coverage programs. Premier Blue Shield also supports the BlueCard Preferred Provider Organization (PPO) programs in Pennsylvania's Central Region, and is used by other carriers who have made an arrangement with Highmark. The Federal Employee Program (FEP) is the largest customer that utilizes this network in the Central, Eastern, and Northeastern Regions of Pennsylvania.

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Western Region KHPW managed care network



The Keystone Health Plan West (KHPW) managed care network in the 29-county Western Region of Pennsylvania supports the managed care products in Highmark's Western Region only. These include health maintenance organization (HMO) coverage plans and the Children's Health Insurance Program (CHIP). This network also supports the Federal Employee Program (FEP) in the western part of Pennsylvania. In addition, this network supports BlueCard PPO programs in the 29-county Western Region.

The network is comprised of highly qualified PCPs, leading medical specialists, and facilities offering a broad range of care. Eligible licensed professional providers practicing medicine in Highmark's Western Region may apply for participation in the network. Professional providers must meet credentialing criteria and sign a Highmark Choice Company Professional Provider Agreement.

Since it supports Highmark's managed care products in the Western Region, this network must also comply with Pennsylvania Department of Health regulations governing managed care organizations. Therefore, Highmark also conducts site visits and medical record reviews of network participating providers' offices and facilities to ensure they meet necessary standards.

Community Blue commercial network



The Community Blue networks, located in Pennsylvania's Western and Central Regions, are select networks that support the commercial Community Blue PPO and EPO products. These products were designed to provide an affordable choice for customers seeking lower cost coverage while still being able to receive high quality, cost-efficient care from highly reputable health care providers.

The Community Blue hospital networks include community and world-renowned hospitals while the physician network includes primary care physicians and specialists who are also part of the larger managed care networks in each region.

Members can locate participating Community Blue providers by using the applicable regional Provider Directory accessible on the regional member websites by selecting **Find a Doctor or RX**.

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3.1 PROVIDER NETWORKS, Continued

[What Is My Service Area?](#)

First Priority Health Network



The First Priority Health managed care network in the 13-county Northeastern Region of Pennsylvania supports the health maintenance organization (HMO) products in this service area. This includes, but is not limited to, BlueCare® HMO, BlueCare® HMO Plus, and the Children’s Health Insurance Program (CHIP).

The First Priority Health network of professional providers and facilities spans throughout the 13-county service area and also includes several hospitals and their participating physicians in contiguous counties in Pennsylvania, New Jersey, and New York. To be included in the network, practitioners and facilities must maintain high quality standards and meet strict credentialing criteria.

Medicare Advantage Networks



The networks are the cornerstones of the Medicare Advantage HMO and PPO programs in Pennsylvania. Medicare Advantage HMO members are required to obtain services from providers participating in the applicable Medicare Advantage network – *except* for urgent or emergent care. Members with Medicare Advantage PPO plans have both in-network and out-of-network benefit options.

The Medicare Advantage preferred provider network supporting Freedom Blue PPO spans a 62-county service area, including all Pennsylvania counties *except* Bucks, Chester, Delaware, Montgomery, and Philadelphia in the Eastern Region.

The Medicare Advantage network supporting Security Blue HMO members (in Pennsylvania’s Western Region only) includes an expansive network of professional and facility providers in the 28-county service area.

Community Blue Medicare HMO and PPO networks are select, high value networks in select counties throughout Highmark’s regions supporting the Community Blue Medicare products. Community Blue Medicare PPO has a broader network of providers than Community Blue Medicare HMO, while the Community Blue Medicare Plus PPO network is limited to Clinton, Lycoming, Sullivan, and Tioga counties with exclusive access to Geisinger Danville facilities and doctors.

To be included in a Medicare Advantage provider network, a provider must participate in the Medicare program itself. For more information on Medicare Advantage, please visit [Chapter 2.2: Medicare Advantage Products and Programs](#).

PLEASE NOTE: The Community Blue Medicare HMO network differs from the network associated with the commercial Community Blue products.

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3.1 PROVIDER NETWORKS, Continued

ACA Select Network



Effective January 1, 2018, the ACA Select Network supports Highmark Affordable Care Act (ACA) *my Direct Blue* HMO and EPO products that are available in certain counties in Pennsylvania. The ACA Select Network is comprised of select local physicians and hospitals that provide quality outcomes at an affordable cost for *my Direct Blue* ACA members in those counties.

Physician practices employed by a hospital or health system in the ACA Select Network will also participate in the network. Network participating providers can be located by using the online Highmark Provider Directory.

Note: Highmark continues to offer ACA PPO plans in most regions that use the broader networks, as applicable.

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Delaware



The Delaware Provider Network spans all three counties in the state of Delaware and also contiguous counties of neighboring states. Highmark Delaware has participating provider contracts with more than 90 percent of Delaware's physicians and health care providers and includes all hospitals in Delaware.

As the leading health benefits company in the state, Highmark Delaware strives to provide members access to leading health care professionals in all specialties. All physicians and practitioners requesting network status with Highmark Delaware are required to complete and participate in the application and credentialing process.

Highmark Delaware's Participating Provider Network supports all products available from Highmark Delaware, including *Blue Classic* traditional, *Blue Choice*® PPO, *Simply Blue* EPO, *Blue Select*® POS, the *MedicFill*® Medicare supplemental program, and the *Blue Care*® Independent Practice Association (IPA) managed care HMO product. The network also supports FEP and BlueCard.

West Virginia



Highmark West Virginia contracts with providers who have service locations within either the state of West Virginia or a contiguous county. Highmark West Virginia uses provider networks for all of its health benefits lines of business.

Highmark West Virginia professional provider networks include the following:

- Indemnity
- Preferred Provider Organization (PPO)
- Point of Service (POS)
- Medicare Advantage Freedom Blue PPO

Continued on next page

3.1 PROVIDER NETWORKS, Continued

[What Is My Service Area?](#)

**West
Virginia**
(continued)



Providers sign a Network Agreement, which includes an Addendum I to Network Agreement for Super Blue PPO and POS Participants. The Network Agreement includes an Addendum II to Network Agreement for Super Blue Select Primary Care Physicians for those primary care physicians who act as care coordinators for members in Highmark West Virginia POS products.

Participation in the Freedom Blue network is governed by an Amendment to Network Agreement for Medicare Advantage PPO Program(s); for certain providers not participating in Highmark West Virginia's commercial networks, this may be a standalone agreement.

New providers contracting with Highmark West Virginia are required to participate in the indemnity, PPO, and POS commercial networks. New providers are encouraged but not required to participate in the Medicare Advantage Freedom Blue PPO network. Network providers may elect to opt out of the Freedom Blue network by providing written notice to Highmark West Virginia pursuant to the Medicare Advantage amendment/agreement.

The West Virginia Small Business Plan (WVSBP) uses the Highmark West Virginia commercial PPO network. Providers may opt out of the WVSBP but remain in the Highmark West Virginia PPO network through an annual opt out process administered by the West Virginia Public Employees Insurance Agency (PEIA).

OBSOLETE

3.1 SELECT DME NETWORK (PA ONLY)

Overview



To provide high-quality, cost-effective options to Highmark members in Pennsylvania, Highmark has contracted with certain durable medical equipment (DME) providers to form the Select DME Network. The more efficient, lower-cost network will provide a better value for Highmark members' health care dollars.

Highmark has carefully evaluated and selected providers for the Select DME Network to ensure that all counties in Pennsylvania have adequate coverage to meet members' needs. Additionally, there are several Select DME Network providers that provide DME on a national scale and are able to serve all counties in Pennsylvania.

[What is My Service Area?](#)

Select DME Network effective January 1, 2017



Effective January 1, 2017, the Select DME Network will be the exclusive network for all Highmark Medicare Advantage plans in Pennsylvania. For coverage of eligible DME services or supplies, Medicare Advantage members must obtain the services or supplies from a provider participating in the Select DME Network.

For Highmark commercial benefit plans, the Select DME Network applies to the highest tier level of Pennsylvania tiered health plans. For example, for a 3-tiered plan such as Connect Blue in western Pennsylvania, the Select DME Network applies to the Preferred tier level. In a two-tiered plan such as Community Blue Flex, Community Blue Premier Flex, and Alliance Flex Blue, the Select DME Network applies to the Enhanced tier level. Highmark commercial members with tiered plans have the option of choosing other DME participating providers not in the Select DME Network; however, receiving services or supplies from non-Select DME Network providers may result in higher out-of-pocket costs for members.

FOR MORE INFORMATION



Highmark provides two versions of the current list of providers in the Select DME Network. You can select a list of [all participating providers](#) or a list [organized by category](#), which includes telephone numbers. These lists of providers in the Select DME Network are also available on the Provider Resource Center. Select **HIGH PERFORMANCE NETWORKS** from the main menu on the left, and then **Select DME Network**.

Select DME Network providers can be contacted directly if you have any questions about the products or services they provide.

Continued on next page

3.1 SELECT DME NETWORK (PA ONLY), Continued

**Referring
Highmark
members to
DME providers**



Providers should refer their Highmark Medicare Advantage patients to Select DME Network providers for their DME equipment and supplies. Receiving services from non-Select DME Network providers would result in higher out-of-pocket costs for the member.

Highmark commercial members can continue to use providers from the broader DME network; however, you should refer Highmark commercial members to Select DME Network providers to receive the highest level of benefits possible.

OBSOLETE

3.1 DIRECTING CARE TO NETWORK PROVIDERS

Overview Highmark network providers must refer members who need additional, non-emergent services to other providers who participate in the network associated with the member's benefit plan (i.e., PPO, POS, Medicare Advantage). This protects the member from higher costs that may be incurred if services are received from a non-network provider.

Background Many of Highmark's products have a requirement that members have all of their care rendered by providers who hold a contract with the appropriate Highmark network.

- Health Maintenance Organization (HMO), Independent Practice Association (IPA), and Exclusive Provider Organization (EPO) products provide no benefits for non-emergent services rendered by non-network providers. An HMO, IPA, or EPO member is responsible for the entire cost of out-of-network services unless in rare cases where a service is not available in the network.
- Preferred Provider Organization (PPO), Point of Service (POS), and open access products feature a lower level of payment when non-emergent services are rendered by an out-of-network provider. A PPO, POS, or open access member who receives a service from an out-of-network provider is responsible for out-of-network deductible and coinsurance amounts before the insurance begins to cover the expense unless in rare cases where the service is not available in the network.

Please see the units of the *Highmark Provider Manual's* Chapter 2, Product Information, for additional program and product information.

Participating provider responsibilities As a provider who participates in a managed care network, it is your obligation to provide services at the most appropriate level and to protect Highmark members from business practices that expose them to unnecessary out-of-pocket expenses. This means, among other things, that when your Highmark members require services that you are not able to provide, you are obligated to direct those members to other providers who participate in the network associated with their benefit program.

You are not permitted to direct Highmark members to out-of-network providers unless the member elects to use an out-of-network provider, has out-of-network coverage, and/or the use of such providers has been authorized by Highmark's Clinical Services or, in some cases, by a Highmark Medical Director.

Continued on next page

3.1 DIRECTING CARE TO NETWORK PROVIDERS, Continued

Locating network providers

The online Highmark Provider Directory allows providers and members to search for Highmark network participating providers. It can be accessed from our public websites. For members who have BlueCard® benefits, this tool can be used to search for any provider within the nationwide Blue Cross Blue Shield system.

Providers and members can access the Highmark Provider Directory from the home page of each of Highmark's regional public websites. Access to all Highmark regional websites is available at highmark.com. Click on the orange **CONSUMERS/MEMBERS/PROVIDERS** tab, and then select the appropriate link under **FOR MEMBERS** for the Highmark service area in which you are located. The Provider Directory is accessed by clicking on **FIND A DOCTOR OR RX**.

Providers can also search for participating providers through NaviNet's **Network Provider Inquiry** and **Network Facility Inquiry** functions.

Quick Reference

Out-of-network services

If a treating provider cannot identify a physician or facility (in or out of network) to which to refer a patient (e.g., for highly specialized, unusual, or infrequently performed services), then the provider may contact Highmark's Clinical Services for assistance.

Highmark care management staff will attempt to identify one or more in-network providers that perform the service in question. If we cannot locate an in-network provider, we will work with other sources to identify out-of-network providers that may perform the service. If the services are medically necessary, Clinical Services will authorize the use of an out-of-network and approve in-network benefits.

Type of provider choice

When more than one type of provider can furnish a particular service or item covered by the member's benefit plan, Highmark generally does not restrict a member's or referring provider's choice of what type of provider to use.

Consistent with provider anti-discrimination law, Highmark plans do not impose limitations or conditions on services, diagnoses, or treatment by a particular type of provider that do not apply equally to all types of licensed providers that customarily provide such services.

Highmark's benefit plans do generally provide that services must be:

- Furnished by licensed (or certified, where applicable) providers practicing within the scope of their license;
- Rendered according to generally accepted medical standards and practices;
- Provided by someone other than an immediate family member; and
- The most appropriate supply or level of service which can be safely and adequately provided to the member in the most cost-effective setting.

3.1 HOW TO REGISTER WITH HIGHMARK

Overview

To be registered on Highmark's files and submit claims to Highmark, eligible providers who are not participating in Highmark's networks must submit their rendering and billing National Provider Identifiers (NPIs).

Information on obtaining an NPI is provided in the section within this unit titled "National Provider Identifier (NPI)."

Submit NPIs to Highmark

To be registered on Highmark's files in these service areas, eligible providers must submit their rendering and billing NPIs to Highmark.

- Fax to : **1-800-236-8641**
 - Mail to: Highmark Blue Shield
Provider Information Management
P.O. Box 898842
Camp Hill, PA 17089-8842
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OBSOLETE

3.1 HOW TO BECOME A PARTICIPATING PROVIDER (PA ONLY)

Overview



Highmark's Participating Provider Network in Pennsylvania services Highmark's traditional programs as well as BlueCard® traditional, point of service (POS), and health maintenance organization (HMO) programs. This is not a credentialed network – a professional provider's admission to the network is based solely on Pennsylvania licensure and the execution of a "Participating Provider Agreement."

Participating Providers agree to perform services for members according to the applicable Participating Provider provisions (Part I and Part II) of the *Highmark Blue Shield Regulations for Participating Providers and Premier Blue Shield Providers*, Pennsylvania state laws, the corporate bylaws governing Highmark Blue Shield, and master contracts.

[What Is My Service Area?](#)

Participating Provider Agreement form



To become a Participating Provider, you must complete a "Participating Provider Agreement." By submitting the completed form, a solo practitioner is entering into the agreement as both "Participating Provider" and "Practitioner." If a group practice, the Participating Provider is entering into the agreement on its own behalf and on behalf of each of its employed practitioners.

The "Participating Provider Agreement" can be found on Highmark's Provider Resource Center. The Provider Resource Center can be accessed via NaviNet® or highmark.com (click on the orange **CONSUMERS/MEMBERS/ PROVIDERS** tab, and then select the link for the Highmark plan in your service area from the options under the **FOR PROVIDERS** heading).

To reach the link for the participating provider agreement form, select **FORMS** from the main menu on the Provider Resource Center, and then click on **Provider Information Management Forms**. In this location, you will also find the [Regulations for Participating Providers and Premier Blue Shield Providers](#).

The completed Participating Provider Agreement can be sent to Highmark along with a copy of your current license as follows:*

- Fax to : **1-800-236-8641**
- Mail to: Highmark Blue Shield
Provider Information Management
P.O. Box 898842
Camp Hill, PA 17089-8842

Once the completed agreement is received and processed, you will be notified in writing of the effective date of your participation.

**If a group practice, submit a copy of the license of each practitioner.*

3.1 PARTICIPATION IN HIGHMARK CREDENTIALLED NETWORKS

Overview

To participate in Highmark's credentialed networks, the professional provider begins the application process through CAQH ProView™ -- the online credentialing database developed by the Council for Affordable Quality Healthcare (CAQH). The CAQH ProView national standardized online system eliminates the need for multiple credentialing applications and significantly streamlines the credentialing process. Practitioners complete one standard application that meets the needs of Highmark and other participating health plans and health care organizations.

Highmark uses CAQH ProView as the exclusive provider credentialing system for all applicable networks. All Highmark network providers in the Pennsylvania and Delaware service areas must use CAQH for credentialing and recredentialing.

Once CAQH ProView registration is completed, the provider will receive additional information for completing the application process for participation in the networks within our service areas.

After careful review of your application, Highmark will advise you in writing of your acceptance or non-acceptance into the network(s). A formal appeals process is available to any provider whose application is not accepted. This information is detailed in the communication you will receive.

IMPORTANT: Mandated WV Uniform Credentialing Form



To initiate the credentialing process, Highmark West Virginia physicians and allied health practitioners must complete the most recent version of the State of West Virginia Uniform Credentialing Form (application), preferably by entering information into the CAQH database, as long as it is printed on the mandated West Virginia Uniform Credentialing Form (application).

[What Is My Service Area?](#)

FOR MORE INFORMATION

For complete details on CAQH ProView and the credentialing process, please see [Chapter 3.2: Professional Credentialing](#).

3.1 DUAL NETWORKS (PA ONLY)

Overview



Some customers choose to have more than one professional provider network support their managed care coverage program in Pennsylvania. These programs have both a primary provider network and a secondary network comprised solely of Highmark Blue Shield's Participating Provider network. The Pennsylvania Insurance Department and Pennsylvania Department of Health have approved these dual-network programs.

Dual-network managed care programs use a separate, supplemental member contract. This contract applies when a member chooses to receive services from a participating provider not in the primary network. Payment under the supplemental contract is based on UCR. Service benefits apply when a Highmark Blue Shield participating provider renders the services.

The Explanation of Benefits form that accompanies the UCR payment states that a Participating Provider must accept the UCR allowance as payment in full for covered services, in accordance with the terms of the Participating Provider agreement. The participating provider may collect any applicable coinsurance or deductibles from the member.

[What Is My Service Area?](#)

OBSOLETE

3.1 ASSIGNMENT ACCOUNTS

Overview

An assignment account is an account established by Highmark to permit one or more individual professional providers, practicing together, to direct Highmark payments to an entity other than the individual provider(s).

An assignment account will be permitted only if the provider(s), as well as the entity to which payment is being directed, meet and continue to comply with guidelines set forth by Highmark.

Eligible entities and arrangements

To establish an assignment account, the following conditions must be met:

- 1) The billing entity must be arranged in one of these manners:
 - a. **Incorporated solo practitioner** – An incorporated solo practitioner who desires to have the corporation recognized as the entity or to use a tax identification number to receive payment from Highmark.
 - b. **Sole proprietorship** – A sole proprietorship is unincorporated, owned by one individual, and its liabilities are the sole proprietor's personal liabilities. The sole proprietor takes the risks of the business for all assets owned. For legal and tax purposes, the business does not exist separately from the owner.
 - c. **Group practice** – Two or more providers practicing as a group may establish an assignment account to have the group recognized as a single entity for purposes of billing and payment. Examples of a typical group practice arrangement are:
 - Two or more providers practice as a partnership;
 - A group of providers form a professional corporation and the corporation becomes the employer of the providers;
 - A provider employs one or more other providers as associates in his or her practice.
- 2) Limited license providers may not be included in a Highmark assignment account which also contains health service doctors (MDs and DOs)*;
- 3) A provider not participating in a Highmark provider network may not be included in a Highmark assignment account which also contains participating providers.

**Exceptions apply in the Medicare Advantage networks in Pennsylvania and West Virginia for MD and DO groups only.*

Continued on next page

3.1 ASSIGNMENT ACCOUNTS, Continued

How to establish an assignment account

To establish an assignment account, complete the [Request for Assignment Account](#) electronic form. This form can also be found on the Provider Resource Center – select **FORMS**, and then **Provider Information Management Forms**.

Note: To establish a Medicare assignment account, call Medicare Provider Enrollment Services at **1-866-488-0549**.

IMPORTANT: Assignment Account Regulations

For complete guidelines for assignment accounts, including detailed descriptions of eligible entities, please refer to the [Assignment Account Regulations](#).

The regulations are also available on the Provider Resource Center under **FORMS**, and then **Provider Information Management Forms**.

Electronic transactions required

All new assignment accounts are required to enroll in NaviNet®, Electronic Funds Transfer (EFT), and paperless Explanation of Benefits (EOB) statements.

NaviNet is Highmark's provider portal, which integrates all insurer-provider transactions into one system (e.g., eligibility and benefit inquiries, claim status inquiries, claim submission, authorization requests, etc.). EFT is a secure process that directs Highmark claim payments to the provider's checking or savings account as directed by your office. Paperless EOB statements reduce the amount of paper flowing into the provider's office.

For information on enrolling in NaviNet, EFT, and paperless EOBs, please see the **Electronic Transaction Requirements** section of this unit.

Keeping Assignment Account information up-to-date

Please inform Highmark of any changes to your assignment account. Failure to keep this data current may lead to incorrect listing in directories viewed by Highmark members, missed mailings or checks, and, possibly, incorrect payments.

Please notify Highmark immediately when any of the following changes:

- Hours of operation
- Practice address (physical location)
- Mailing address if different from practice address
- Specialty (requires signatures of Assignment Account members if you are changing their individual specialties as well)
- Tax Identification Number (TIN)
- Additions/deletions of Assignment Account members
- Telephone number, including area code (member access phone number)
- Fax Number

Continued on next page

3.1 ASSIGNMENT ACCOUNTS, Continued

Notification of new or departing practitioners

When a practitioner leaves or a new practitioner joins your assignment account, please provide prior notice to Highmark.

Please be sure to notify Highmark of a departing provider's new address and tax identification number – an employer identification number or Social Security Number, as appropriate. Highmark will send written notification to departing providers to advise them of the transfer of their profiles to their individual provider number.

NaviNet is the preferred method for notifying Highmark of practitioner changes. Select **Provider File Management** from the main menu on Highmark Plan Central. Please see the next page for additional information on making changes to an existing assignment account.

Restrictions

Highmark has the right to deny a request to add to or delete any practitioner from an Assignment Account. Highmark will always deny such a request when a utilization case is open that is pending resolution.

How to make changes to an existing assignment account

You can notify Highmark of any changes to your existing assignment account quickly and easily by using NaviNet, Highmark's preferred method for updating your assignment account information. Select **Provider File Management** from the main menu on Highmark Plan Central.

- **Practitioner Updates:** For new practitioners, click on the **Add a Practitioner** link. To change information for an existing practitioner or to remove a practitioner, select the practitioner, and then click on **Edit** or **Delete**, as applicable.
- **Address Updates:** To add a new location, click on **Add an Address**. To make changes to an existing address, select the address, and then click **Edit** or **Delete**, as applicable.

If you are not NaviNet-enabled, complete the applicable form as follows:

- **Practitioner Updates:** For practitioner changes, use the [Request for Addition/Deletion to an Existing Assignment Account](#) electronic form.
- **Address Updates:** For adding new practice locations or to make changes to an existing location, complete the [Provider File Maintenance Request](#) form.

These forms are also available on the Provider Resource Center – select **Forms**, and then **Provider Information Management Forms**.

Continued on next page

3.1 ASSIGNMENT ACCOUNTS, Continued

How to make changes to an existing assignment account
(continued)

The completed **Provider File Maintenance Request** form can be faxed or mailed as follows:

- Fax to : **1-800-236-8641**
- Mail to: Highmark Blue Shield
Provider Information Management
P.O. Box 898842
Camp Hill, PA 17089-8842

Note: Changes to your electronic funds transfer (EFT) account can be completed in NaviNet by your practice's "EFT Responsible Party." Your NaviNet Security Officer must first enable the transaction for the EFT Responsible Party in order for the EFT Attestation and Registration button to display on the Highmark Plan Central menu.

IMPORTANT!

If going from a solo practice to adding additional practitioners, you will need to create a new assignment account.

OBSOLETE

3.1 PROVIDER TAX IDENTIFICATION NUMBERS

Highmark's use of provider tax identification numbers

In addition to claims processing, Highmark uses a provider's tax identification number to accurately identify providers for other business functions and with outside vendors/partners during the normal course of business operations.

Highmark strongly discourages the use of Social Security numbers in lieu of business tax identification numbers whenever it requests a provider's tax identification number.

A provider who chooses to submit his or her Social Security Number as a tax identification number hereby acknowledges, understands, and agrees that Highmark will treat the Social Security Number in the same manner in which it handles other providers' business tax identification numbers and shall not be liable to such provider for any intentional or unintentional disclosures of such Social Security Number.

How to obtain a Federal Employer Identification Number (EIN)

To avoid using your Social Security Number as your provider tax identification number, you may instead use a Federal Employer Identification Number (EIN) issued by the Internal Revenue Service (IRS).

To obtain an EIN, please visit [irs.gov](https://www.irs.gov).

OBSOLETE

3.1 NATIONAL PROVIDER NUMBER (NPI)

Background

The Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) mandated the adoption of standard unique identifiers for health care providers and health plans.

The purpose of these provisions is to improve the efficiency and effectiveness of the electronic transmission of health information. The Centers for Medicare & Medicaid Services (CMS) developed the National Plan and Provider Enumeration System (NPPES) to assign these unique identifiers.

What is the “NPI”?

The National Provider Identifier (NPI) is a 10-digit numerical identifier for providers of health care services. The NPI is a result of the CMS mandate which supports the HIPAA simplification standards. All eligible health care providers receive one standard number which they are required to use when submitting health care transactions. It is intended to improve the efficiency of the health care system and to help reduce fraud and abuse.

Individual practitioners receive one NPI even when they are dual-licensed under multiple provider types (e.g., a practitioner holds both an MD and DMD license). Organizational providers (group practices and facilities) receive one NPI for the legal entity and any subpart that meets the covered health care provider definition if it were a separate legal entity. Organizations may request additional NPIs for subparts as long as the identifying data is unique.

How to obtain an NPI

NPPES is the central electronic enumerating system in place for assigning NPIs. Health care providers can apply for NPIs in one of three ways:

- Complete the web-based application process online at: <https://nppes.cms.hhs.gov>
 - Download and complete a paper application from the NPPES website and mail to NPPES.
 - Call NPPES for a paper application: **1-800-465-3203** (TTY: 1-800-692-2326)
-