Request for Assignment Account

Please complete this form in its entirety—*including the Assignment Account Agreement on Page 3*—to request an Assignment Account number with the Plan. An Assignment Account is the Plan's term for a single provider or group of providers who wish to assign their right of payment to a single entity under a tax identification number.

Please note that this form may be used for providers of Highmark Inc. ("Highmark") and certain of its affiliates: Highmark West Virginia Inc. ("Highmark WV"), Highmark Health Insurance Company ("HHIC") and Highmark BCBSD Inc. ("Highmark DE"). Highmark, Highmark WVA, HHIC and Highmark DE may each be referred to herein as the "Plan". When the term "Plan" is used, it will mean each Plan that the Provider contracts with as a network provider. This form covers specific products of the Plan, as offered in a Plan's service area and for which the Provider is credentialed.

Starting on January 1, 2019, this Fillable PDF Form will be discontinued in favor of our Electronic Forms, which are processed faster than Fillable PDF Forms. The Electronic Forms can be found on the Provider Resource Center in your region under "Forms", "Provider Information Management Forms".

Assignment Account Information

Name of Account (DBA name) _____

Tax ID _____ Tax ID Name _____

Practice Email _____ Type 2 (Group) National Provider Identifier (NPI) _____

Name(s) of Provider(s) in Assignment Account (attach a separate sheet if necessary)

If a practitioner needs to be credentialed, visit the Provider Resource Center via NaviNet or the public website in your region and complete the steps by clicking "Credentialing", then "Initial Credentialing Request Form".

Practitioner Name	*DOB*	*CAQH ID*	*Type I NPI (Individual)*	*Specialty*	*Practitioner Email*

Assignment Account Address Information

Main Practice Address (primary physical practice location) *(PO Box numbers are **NOT** acceptable)*

Group PROMISE ID at this location _____

Address 1 _____

Address 2 _____

City _____ State ____ Zip+4 _____

Telephone number: _____

Fax number: _____

Practitioner names/PROMISE IDs at this location* / Practitioner PROMISE ID

① _____

② _____

③ _____

Member Access Number: _____ Patients call this number to make an appointment for this location

Office hours	*Monday*	*Tuesday*	*Wednesday*	*Thursday*	*Friday*	*Saturday*	*Sunday*

Additional Practice Address* Group PROMISE ID _____

Address 1 _____

Address 2 _____

City _____ State ____ Zip+4 _____

Telephone number: _____

Practitioner names/PROMISE IDs at this location* / Practitioner PROMISE ID

① _____

② _____

③ _____

Fax number: _____

Office hours	*Monday*	*Tuesday*	*Wednesday*	*Thursday*	*Friday*	*Saturday*	*Sunday*

** Use a separate sheet for additional practice addresses and/or additional practitioners at each location.*

Mailing Address (if different than Main Practice and Check Address)

Address 1 _____

Address 2 _____

City _____ State ____ Zip+4 _____

Telephone number: _____

Fax number: _____

Check Address (where checks are sent) Is this a lockbox? ❑ Yes ❑ No

Address 1 _____

Address 2 _____

City _____ State ____ Zip+4 _____

Telephone number: _____

Fax number: _____

Patient Age Ranges

Does your practice limit the age of patients you treat? ◯ Yes ◯ No

If **YES,** what ages do you treat? _____ Minimum _____ Maximum

Highmark Blue Shield is an independent licensee of the Blue Cross and Blue Shield Association

Open to New Patients

Is your practice open to new commercial patients? ◯Yes ◯No
Is your practice open to new Medicare patients? ◯Yes ◯No
Is your practice open to new Medicaid patients? ◯Yes ◯No

NaviNet Contact Information : Please provide the name of your office staff that is responsible for NaviNet:

NaviNet Contact Name: _____ Telephone Nbr: _____

Email address: _____

Do you currently have NaviNet with the Plan or any other health insurance carrier? ◯Yes ◯No

If **YES,** please provide your NaviNet Username: _____
This information will be used to link your new number to your current NaviNet setup.

Urgent Care Facility/ Retail Clinic Entities / Medical Aid Units *only*

Please indicate if the requesting entity is: ◯Urgent Care Facility OR ◯Retail Clinic OR ◯Medical Aid Unit

More Information Regarding This Assignment Account

Is this request for: ◯School-based clinic? ◯Rural Health Clinic (RHC)? ◯Federally Qualified Health Clinic (FQHC)?

If this is a school-based clinic, are you open to the public? ◯Yes ◯No

Legal Entity Requesting Account – Please check one:

◯Sole Proprietorship ◯Partnership (General) ◯Partnership (Limited) ◯Non-Profit Corporation ◯Business Corporation
◯Professional Corporation ◯Limited Liability Partnership ◯Limited Liability Company (including restricted professional companies)
◯Health Care Facility ◯Other (explanation must be provided) _____

Relationship Between Legal Entity and Provider – Please check one:

◯Employed Relationship ◯Solo Practitioner ◯Member/Shareholder ◯Group billing under a Health Care Facility Tax ID
◯General Partner ◯Other (explanation must be provided) _____

Behavioral Health Providers

If you are a Behavioral Health Provider, please indicate if you will be providing any of the following three services:

IOP ◯Yes ◯No Partial Hospitalization ◯Yes ◯No Autism Services ◯Yes ◯No

Groups With Additional Assignment Accounts

If you are currently billing with another Assignment Account (PA or DE) or Pay-To Account (WV), will you be terminating that account?

◯Yes ◯No If **YES,** when? _____ (date)
Highmark ID of terminated Assignment Account (PA or DE) or Pay-To Account (WV): _____

If *terminating* an Assignment Account (PA or DE) or Pay-To Account (WV), are you still available to members at another location?

◯Yes ◯No If **YES,** name and address of new location? _____
Effective date of new location? _____ (date)

If **NO,** please note that ***members will be notified of your network termination from the above-terminated group.***

E-Subscribe Information

E-Subscribe is defined as: you elect to only receive electronic communication of the publication of the PRN and Behind The Shield, Special Bulletins, Office Manual and PRC Updates. You will receive these communications in the provided email address:

Email address: _____

❑ **Yes, I would like to sign up for E-Subscribe** By selecting this box, you hereby agree to electronically receive administrative requirements that are legally binding upon contracted providers and upon the Plan. By selecting this box, you hereby acknowledge that such publications will be sent to you only by electronic means. Please maintain such electronic publications in the event of future questions and to ensure such compliance. You may unsubscribe from this list at any time on future emails from the Plan by clicking the "Unsubscribe" link in the email.

Radiology Services

Does this group provide radiology services? ◯Yes ◯No

If **YES,** please reference the Highmark Radiology Management Program information on our Provider Resource Center.

Assignment Account Agreement of Provider

1. We hereby agree to only bill those services performed by individual providers in the group account.
2. We certify that each individual provider in our account agrees to assign his/her fee to the group account ("our account" or "account").
3. We agree that every 1500 claim form submitted will include the provider number of the individual provider who actually performed the service (place in Block 24K of the claim or in any other location as determined in the future).
4. We agree that the group and each individual provider in our account will be jointly and severally liable for any overpayment that the group receives.
5. We agree to notify each applicable Plan in writing of any subsequent changes in the composition of the group prior to the effective date of each change.
6. We agree to inform each applicable Plan of any change in the group's contractual arrangements that directly or indirectly impact this Assignment Account (PA or DE) or Pay-To Account (WV) or that would necessitate the Plan's payments to be made to some entity other than that designated in this Assignment Account (PA or DE) or Pay-To Account (WV) application.
7. [For PA providers only] We certify that we will not bill for any professional services that are reimbursed through another Pennsylvania Blue Cross Plan. All claims for these services will be submitted on the 1500 claim form for all appropriate Blue lines of business patients.
8. We understand that for certain networks all individual providers in our account must be fully credentialed in order for the group to be able to bill directly for that network and before rendering services to members.
9. We have carefully reviewed the forms and applications associated with the establishment of this agreement and each individual provider in our account has verified the accuracy and completeness of all information provided.
10. We have carefully reviewed this form and each individual provider in our account certifies and represents that the requested account will satisfy the requirements, and when established, that the account will not represent an ineligible arrangement as described in Part III of the Highmark Assignment Account Regulations, available at the Provider Resource Center at www.highmark.com.

On behalf of the group, I certify that all individual providers in the group account have reviewed and agree to be bound by the Highmark Assignment Account Requirements. I represent and warrant I have the authority to bind the individual providers and sign on their behalf.

By signing this Assignment Account form, we are agreeing to the Assignment Account Regulations (version 1.0) found on the Provider Resource Center. You'll find the link to the Provider Resource Center on our NaviNet Plan Central page. If you don't have access to NaviNet, you'll find the link to the Provider Resource Center on our public website in your region.

Signature of Authorized Representative of Group	Date
Title	Telephone Number

Please fax the completed form to:
Provider Information Management at
(800) 236-8641