RESET

Provider File Creation Request
COVID-19 Vaccination Administration

This form applies to, and should be completed by, nonparticipating providers licensed in New Jersey who are able to provide COVID-19 vaccines to Horizon Blue Cross Blue Shield of New Jersey (Horizon BCBSNJ) and/or Horizon NJ Health members.

Completing this form will help us ensure that we're able to quickly process claims and provide reimbursement claims submitted for the administration of COVID-19 vaccines.

Please email this completed form and appropriate supporting documentation to: COVID19_Credentialing@horizonblue.com.

If you have questions, please call **1-800-624-1110** to speak with a Horizon BCBSNJ Provider Service Representative or call **1-800-682-9091** to speak with a Horizon NJ Health Provider Service Representative.

This information is required to add your information to our files and claim processing systems. Completion and submission of this form does not constitute participation with Horizon BCBSNJ or Horizon NJ Health.

DOCUMENTATION REQUIRED

1. **Request Letter**: Please draft a request on your organization's letterhead that we add your information to our provider files to process claims submitted for COVID-19 vaccination administration.

2. **Tax Information**: Please provide one of the following:

   - ○ **W9** copy
   - ○ **Form SS4 / Application for Employer Identification Number** copy showing applicable Tax Identification Number and Federal Classification.

3. **NJ License Information**: To include your information in our files, we need to confirm that you are licensed by the State of New Jersey to provide services to our members. Please select the appropriate option below and provide documentation as appropriate.

   - ○ My provider/location is included on the State of New Jersey's NJ COVID-19 Vaccine Locations: For Eligible Recipients webpage. (*Your inclusion on this site confirms your licensure*).

     Please note that Horizon BCBSNJ has no control over the content on the State of New Jersey's webpages nor do we have control over the frequency of updates to the content on these pages.

   - ○ A copy of a **License** for any provider practicing with your group/organization.

PROVIDER DETAILS

Provider Name _____

Provider Specialty _____ Tax ID Number _____

Type 1 NPI _____ Type 2 NPI _____
(for individual practitioners) *(for group practices/facilities)*

Street Address _____

City _____ State _____ ZIP _____

Contact Name _____ Contact Title _____

Contact Phone _____ Contact Email _____

(Continues)

VACCINE ADMINISTRATION LOCATIONS

Please provide details about your Vaccine Administration locations below. Please include a separate sheet to document additional Vaccine Administration locations.

Location 1

Address _____

City _____ State _____ ZIP _____

Phone _____ FAX _____

Location 2

Address _____

City _____ State _____ ZIP _____

Phone _____ FAX _____

Location 3

Address _____

City _____ State _____ ZIP _____

Phone _____ FAX _____

Location 4

Address _____

City _____ State _____ ZIP _____

Phone _____ FAX _____

Location 5

Address _____

City _____ State _____ ZIP _____

Phone _____ FAX _____

Location 6

Address _____

City _____ State _____ ZIP _____

Phone _____ FAX _____

NEED INFORMATION ABOUT CLAIMS?

Visit our website at HorizonBlue.com/providers for information about claim-related topics as Claim Submission & Billing and Electronic Data Interchange (EDI).