FY24 Provider Contact Form – Breast and Cervical Cancer Early Detection Program

General Information (as shown on Substitute W-9)		
Name (to appear in Provider Listing): ……		
Federal EIN: ☐☐-☐☐☐☐☐☐☐		NM CRS ID #: ☐☐-☐☐☐☐☐☐-☐☐☐
Unique Entity ID: ☐☐☐☐☐☐☐☐☐☐☐☐		**SAM.gov Registration Expiration date:** ☐☐☐☐☐☐
Mailing address:		
City:	State:	ZIP:
Service Area [County(ies)]		
Main Contact Person (person who coordinates BCC Program services at the clinic/health system)		
Name:		Email:
Phone:	Ext.	Fax:
Authorized Representative for Provider Agreement (person who signs agreement)		
Name:		Email:
Phone:	Ext.	Fax:
Authorized Representative for Patient Navigation (licensed individual designated, per agreement)		
Name:		Email:
Phone:	Ext.	Fax:
Authorized Representative for Payments (person who reconciles payments)		
Name:		Email:
Phone:	Ext.	Fax:
*Please see substitute W-9 Form for payment information.		
Authorized Representative for Billing (person who submits billing/claim status requests)		
Name:		Email:
Phone:	Ext.	Fax:
External (Third Party) Billing Company, if applicable*		
Name of Company:		
Contact Person Name:		
Phone:	Ext:	Fax:
Email:		
* Per the provider agreement, all requests for reimbursement must include the HCFA or UB-04 claim form, results such as pathology, mammogram reports, anesthesia logs, and completed BCC Program Screening/Referral Form. Third party billing company may be contacted by BCC Program if claims submitted lack documentation required for reimbursement.		

Please mail completed Provider Contact Form with signed agreement and accompanying documents to:

Breast and Cervical Cancer Early Detection Program
BCC Program Billing Department
5300 Homestead Road NE, Suite 100
Albuquerque, NM 87110

Contact us at: (505) 841-5860 or (505) 252-3050
or visit the *Providers* page on our website: https://www.nmhealth.org/about/phd/pchb/bcc/.