

# Special Bulletin

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## **New Opportunity to Make More Information about Your Practice Available to Highmark Members**

At Highmark, we continually look for ways to support your relationship with your patients and to help promote the many tools you can use to achieve this important goal.

### **Expand Your Online Practice Information**

Today's patients are using technology more than ever to help them make health care decisions. The Internet is now a widely popular tool that offers a multitude of resources to the health care consumer and gives them easy access to publicly available data. To help you take advantage of this trend, Highmark is offering you the opportunity to expand the information about you and your practice that is currently available in our online provider directory, available on our Web site.

### **Complete and Return the Enclosed Form within 30 days.**

The enclosed form will help us gather more information about your practice that we can make available to your current and potentially new Highmark patients. Building upon the general data we now have online, such as practice location and specialty, we are looking to add more detailed information, such as electronic prescribing ability, credentialing, electronic medical records, etc.

The information you provide to us using the enclosed form will be displayed in our provider directories, giving patients an enhanced view of your practice, the services you offer and your credentials. Beginning in 2007, these elements will be an integral part of the patient's expectation when viewing your information online.

Many other health care Web sites already include these additional provider details, so we strongly encourage you to take advantage of this opportunity to stay competitive in marketing your practice. Providers who do not submit these voluntary elements will still appear in our directories, but will have "Unknown" displayed in the spaces where the enhanced information was not supplied.

Please complete the enclosed form and fax it back to us within 30 days of receipt at the number listed on the bottom of the form. Or, return it by mail using the enclosed postage-paid envelope.

Thank you for taking the time to provide this important service to your patients, our members. If you have any questions regarding this request, please contact your Provider Relations representative, or you may contact Provider Data Services at 1-866-763-3224.



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Camp Hill, PA 17089

# Highmark Enhanced Provider Information

MNT TR

Please fill out the applicable information below and submit your completed form to Highmark.

BS ID: \_\_\_\_\_

Name:

Location:


## What services are available at this location?

Does Not Apply

- |  |   |
|--|---|
| <input type="checkbox"/> IV Hydration Treatment            | <input type="checkbox"/> Flexible Sigmoidoscopy     |
| <input type="checkbox"/> Drawing Blood                     | <input type="checkbox"/> Pulmonary Function Testing |
| <input type="checkbox"/> EKG                               | <input type="checkbox"/> Allergy Injections         |
| <input type="checkbox"/> Asthma Treatment                  | <input type="checkbox"/> Allergy Skin Testing       |
| <input type="checkbox"/> Physical Therapy                  | <input type="checkbox"/> Osteopathic Manipulation   |
| <input type="checkbox"/> Age-Appropriate Immunization      | <input type="checkbox"/> Care of Minor Lacerations  |
| <input type="checkbox"/> Tympanometry/Audiometry Screening | <input type="checkbox"/> Pelvic/PAP Exams           |

## Patient Parking Facilities

Onsite (Adjacent to building)  Free or  Paid

## Electronic Medical Records

## What mid-level or other clinical staff provide services to patients at this location?

Does Not Apply

- Nurse Practitioner  Physician Assistant  Mid-Wife  RN

Changes will be made to Highmark's provider database based on the information contained on this form. Please sign below and return to Highmark in the enclosed postage-paid envelope, or fax to 800-236-8641.

Print Your Name: \_\_\_\_\_ Title: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_