BCBSNC Provider Application for Participation

This application is to be used if you wish to become a participating provider facility with BCBSNC. This application is not a contract.

Please follow the applicable [Credentialing instructions](http://www.bcbsnc.com/content/providers/application/instructions.htm) outlined on BCBSNC's Provider Website for the credentialing criteria in order to complete the credentialing process.

Credentialing Department

You may also mail the completed form to:

Blue Cross and Blue Shield of North Carolina

P. O. Box 2291 Durham, NC 27702

To ensure accuracy, please type your information onto this form and fax it to 919-765-7016 or email to [Credentialing@bcbsnc.com.](mailto:Credentialing@bcbsnc.com) If you have any questions about completing this form, call the Credentialing Department at 919-765-3492.

Complete a separate application for:

* Each site location
* Each organization with a unique Federal Tax Identification Number

# Application Type

 Initial Request  Recredentialing

*Please check all Plan(s) you are applying for:*

* Blue Cross and Blue Shield of North Carolina (BCBSNC) Managed Care Networks
* Blue Medicare HMO and Blue Medicare PPO Networks

Is this application for the addition of a new site to your current contract?

Yes No

Is this application due to a physical address change or practice relocation? Yes No Please provide the old address and new address below

Old Address:

New Address:

# Provider Type

Please indicate service type for which you are applying:***\*\*PLEASE SEE APPENDIX A IF APPLYING FOR A BEHAVIORAL HEALTH FACILITY TYPE(S)\*\****

|  |  |
| --- | --- |
| **BCBSNC Managed Care Networks and Blue Medicare HMO and Blue Medicare PPO Networks** | |
| Ambulatory Surgery Center | Home Durable Medical Equipment Company |
| Dialysis Facility | Home Health Agency |
| HDME (Diabetic Supplies Only) | Home Infusion Therapy (HIT) Agency |
| HDME (Orthotics and Prosthetics) | Reference Laboratory |
| HDME (Breast Prosthesis Only) | Skilled Nursing Facility and/or Hospital with Skilled Nursing Beds |
| Hospital | Specialty Pharmacy |
| Ambulatory Infusion Centers |  |
| **BCBSNC Managed Care Networks Only** | |
| Birthing Center | Private Duty Nursing Agency |
| Hospice Agency |  |
| **Blue Medicare HMO and Blue Medicare PPO Networks Only** | |
| Ambulance | Mobile X-ray |
| Cardiac Event Monitoring | Independent Diagnostic Testing Facility |
| Free Standing Radiology Facility | Sleep Centers |
| Home Durable Medical Equipment (Cardiac Event Monitoring Equipment Only) |  |

**APPENDIX A: BEHAVIORAL HEALTH FACILITIES**

### **Please indicate service type for which you are applying *AND* indicate the unique NPI. PLEASE ALSO INDICATE THE PRIMARY NPI BY CIRCLING (based on highest level of service):**

|  |  |
| --- | --- |
| **BCBSNC Managed Care Networks and Blue Medicare HMO and Blue Medicare PPO Networks** | |
| Opioid Centers *(STATE LICENSE MUST INDICATE ONE OR MORE OF THE FOLLOWING CATEGORIES)*  Outpatient Opioid Treatment (3600) | **NPI:** |
| |  |  | | --- | --- | | Partial Hospitalization *(STATE LICENSE MUST INDICATE ONE OR MORE OF THE FOLLOWING CATEGORIES)*  1100 (Partial Hospitalization for Individuals who are acutely Mentally Ill) | **NPI:** | | |
| **BCBSNC Managed Care Networks Only** | |
| Residential Treatment Facility *(STATE LICENSE MUST INDICATE ONE OR MORE OF THE FOLLOWING CATEGORIES)*  1900 (Psychiatric Residential Treatment for children and adolescents)  3400 (Residential Treatment-Individuals with Substance Abuse Disorders) | **NPI:** |
| Intensive Outpatient Facility *(STATE LICENSE MUST INDICATE ONE OR MORE OF THE FOLLOWING CATEGORIES)*  4400 (Substance Abuse Intensive Outpatient Program)  4500 (Substance Abuse Comprehensive Outpatient Treatment) | **NPI:** |
| General Psychiatric Intensive Outpatient Facility *(NO LICENSE REQUIRED. I.E. Eating Disorders, Autism, Depression)* | **NPI:** |

**Provider Information**

Please complete the following information for the location being credentialed or contracted.

|  |  |  |
| --- | --- | --- |
|  | As it appears on W9: |  |
| 1. Provider's Legal Name: |  |  |
| Physical Street Address: |  |  |
| Suite/Building: |  |  |
| City, State, Zip: |  | County |
| Telephone and Fax: | Tel\_( ) | Fax\_( ) |
| Web address: |  |  |
| 2. DBA (doing business as): |  |  |
| 3. NPI: ***(complete for non-behavioral health facilities only)*** |  |  |

*(Type 2 National Provider Identification Number applicable to the specialty checked above)*

1. Tax Identification Number:
2. Medicare Number: Part A:

*(Please also provide a copy of your W-9)*

1. Contact person for questions

about this form: Contact person's email: Contact person's phone and

|  |  |  |
| --- | --- | --- |
| fax: | Tel\_( ) | Fax\_( ) |
| 7. Remittance address: (if different) |  |  |
| Remittance City, State, Zip |  | County |
| Remittance phone and fax: | Tel\_( ) | Fax\_( ) |
| 8. Counties served by this facility: |  |  |

Mgmnt or Parent Company

Part B:

Title:

(*If additional space is needed please add a separate page*)

1. Does your organization submit claims electronically? Yes No
2. Is your entity a Physician owned facility? If no, please describe the ownership:

Yes No

|  |
| --- |
| **Home Durable Medical Equipment**  (The BCBSNC Network is closed for Diabetic Supplies and Equipment, Ostomy, Wound Care, and Urological Supplies and Equipment to **NEW** providers effective 8/1/2014 but is currently open for Blue Medicare providers.) |
| **Home Health Agency**  All of the following services must be provided in order to meet contracting requirements. Please indicate each service that you provide:  Skilled Nursing Visits Speech Therapy Physical Therapy Home Health Aide Occupational Therapy Medical Social Services |
| **Home Infusion Therapy**  All of the following services must be provided in order to meet contracting requirements. Please indicate each service that you provide:  Pharmacy Nursing Supplies |
| **Hospice Agency**  Please indicate type of care:  Inpatient: number of beds Resident/Respite: number of beds |
| **Private Duty Nursing Agency**  All of the following services must be provided in order to meet contracting requirements. Please indicate each service that you provide:  R.N. L.P.N. |

## Skilled Nursing Facility

Are you qualified and enrolled with the National Supplier Clearinghouse (NSC) as a Medicare Certified DMEPOS supplier? Yes No

If yes, please enclose a copy of your Supplier Letter (approval letter) received from the NSC.

## Specialty Pharmacy

**Please review Additional Business Requirements for Specialty Pharmacy on the Blue Cross and Blue Shield of North Carolina website @** [**www.bcbsnc.com/providers**](http://www.bcbsnc.com/providers) **under Forms and Documentation prior to completing this application.**

Provider must meet all three of the following criteria in order to meet contracting requirements. Please check the criteria you meet below:

Provide **all** Medicare Part B drugs (oral & infused)

Provide these drugs directly to physicians

Provide these drugs directly to Members

# Other Information

* 1. Has your organization's license to practice ever been limited, suspended or revoked? Yes No
  2. Has your organization ever been sanctioned, expelled or suspended from receiving payment under the Medicare or Medicaid programs?

Yes No

* 1. Has your organization been named in any malpractice actions in the last 5 years? Yes No

If you have answered “YES” to any questions above, please attach an explanation, including the specific details of each incidence.

* Number of cases less than $200,000
* If greater than $200,000 actual or anticipated, include the occurrence date, settlement date, and nature of case.

# Attestation

I certify that all the information submitted in this application is true and accurate to the best of my knowledge, and agree to promptly provide BCBSNC with notice of any changes in the submitted information, which occur from time to time. I also agree to promptly provide BCBSNC with such additional information as is requested by it in its review of my application. I understand that this application is not a guarantee of network participation. Further I hereby certify that I will not disclose any proprietary and/or otherwise competitively sensitive information of Plans to any person not authorized to receive it in writing in advance by the Plans without regard to the outcome of the application process.

Signature: Printed Name: Title: Date:

**We only accept a signature of the Authorized Representative of the company.**

**Legal Contract Notice Information:**

Name: Title: Organization: Address:

**Credentialing Mailing Address:**

Name of Person

Completing Application: Title Address: Phone Number: Facsimile Number: Email: