

Documents Required in Support of Recredentialing Application

Please submit the following information with your application:

- A copy of your current accreditation certificate
- If not accredited a copy of your most recent CMS review
- A copy of your current general liability malpractice insurance face sheet, which must include current coverage dates, facility name, and limits of coverage. Minimum coverage \$1 million occurrence/\$3 million aggregate.
- A copy of current Medicare & Medicaid EOB's

In addition, the following information is also needed:

If you are a **Hospital, Ambulatory Surgical Center, Birthing Center, Skilled Nursing Facility, Home Health, Hospice, or Private Duty Nursing** provider please also submit the following:

- A current copy of the Division of Health Service Regulation License
- A copy of the policy and procedure for coverage arrangements with a participating provider and hospital, in the event of an emergency situation (Birthing Centers Only).

If you are a **Home Infusion** provider please also submit the following:

- A current copy of the Division of Health Service Regulation License and Board of Pharmacy Permit-Infusion Services Permit.

If you are **Home Durable Medical Equipment, Durable Medical Equipment (Diabetic Supplies Only), Durable Medical Equipment (Equipment Only), Orthotics & Prosthetics, or Cardiac Event Monitoring Equipment** provider please also submit the following:

- A current copy of the Division of Health Service Regulation License or Board of Pharmacy Permit-Devise Dispensing Permit or Board of Pharmacy Permit-Devise and Medical Equipment Permit.

If you are a **Dialysis Facility** please also submit the following:

- A current copy of the CLIA certification or registration (Clinical Laboratory Improvement Amendments) and/or ACR (American College of Radiology).
- A copy of the current Utilization Management Program.
- A copy of the current Quality Management (Quality Assurance) Program.
- A copy of the current Infection Control Plan to include infection rates and transfers from the Dialysis Center(s) to Acute Care Centers.
- A copy of all current services provided at the facility.
- A current copy of the Division of Facility Services/ ESRD Facility Survey Report.
- A copy of the facility's one year of quarterly reporting of quality outcomes data for the following K/Dialysis Outcome Quality Initiative Indicators (K/DOQI):

*Urea Reduction Ration (URR)
*Urea Kinetic Modeling (Kt/V)
*Hemoglobin

*Hematocrit
*Albumin

PROVIDER APPLICATION FOR PARTICIPATION

Blue Cross Blue Shield of North Carolina

Credentialing Department
Blue Cross and Blue Shield of North Carolina
P. O. Box 2291
Durham, NC 27702
Fax Number: 919-765-7016
Telephone 919-765-4575

Please follow the applicable Credentialing instructions outlined on BCBSNC's Website www.bcbsnc.com.

Complete a separate application for:

- **Each site location**
- **Each organization with a unique Federal Tax ID Number**

W9 Information

The following list shows which type of identification number you should provide depending on your type of organization:

<u>TYPE OF ORGANIZATION</u>	<u>TYPE OF I.D. NUMBER</u>
Corporation	Federal I.D. Number
Partnership	Federal I.D. Number
Sole Proprietorship	Social Security Number
Individual	Social Security Number

If you are an individual or sole proprietor, your own name is to be reported on the first line of the form, NOT a business or trade name. Please complete a W-9 form for each different taxpayer identification number. In addition, if your organization is a corporation or partnership, please submit a copy of your Employer Identification Number Notification (Form Letter 147C) from the IRS for each different employer identification number. If you have any questions regarding this form, you may call 1-800-829-1040. Your timely response will allow us to comply with IRS regulations and prevent you from being penalized.

Please Note:

- *The legal name must be the same on all supporting documents.*
- *Printed or typed, leaving no blank spaces.*

Does your organization submit claims electronically? Yes No

A. **Federal Tax Identification Number:** _____
(Please provide your W-9)

B. **Provider Number(s)**

Please list **all** BCBSNC provider numbers associated with this Tax ID number

Please list National Provider Identifier (NPI) number _____
(Required)

C. **Accreditation** Yes No

If yes, please indicate which Accreditation body you are affiliated:

Effective Date _____ Expiration Date _____

D. **Medicare Certified** Yes No

If you have checked "YES", please provide your certification number.

Medicare No. _____ Medicare No. _____
Part A Part B

If you have checked "No", please provide an explanation why you are not Medicare certified:

E. **Medicaid Certified** Yes No

If you have checked "YES", please provide your certification number.

Medicaid No. _____

If you have checked "No", please provide an explanation why you are not Medicaid certified:

F. **Change In Name/Ownership:**

If your organization has changed names and/or ownership in the last 3 years, please provide the organization's previous names and addresses under which credentialing/recredentialing was processed.

G. Other Information

If you are not currently accredited, and you have answered "YES" to any question below, 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.**

- A. Has your organization's license to practice ever been limited, suspended or revoked?
Yes No
- B. Has your organization ever been sanctioned, expelled or suspended from receiving payment under the Medicare or Medicaid programs?
Yes No
- C. Has your organization been named in any malpractice actions in the last 5 years?
Yes No

2. PROVIDER TYPE Please indicate services for which you are applying. Additional Credentialing instructions can be found at <http://www.bcbsnc.com/content/providers/application/instructions.htm>.

BCBSNC HMO/PPO Managed Care Networks and Blue Medicare HMO/PPO Networks

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
- Home Health Aide
- Speech Therapy
- Occupational Therapy
- Physical Therapy
- Medical Social Services

Home Infusion Therapy (HIT) Agency

(All of the following services must be provided in order to meet contracting requirements: pharmacy, nursing and supplies) **Home Durable Medical Equipment Company**

- HDME (Diabetic Supplies Only)**
- HDME (Orthotics and Prosthetics)**
- HDME (Breast Prosthesis Only)**

- Dialysis Facility**
- Ambulatory Surgery Center**
- Hospital**

Please indicate with a “YES” or “NO” if you provide the following In Patient Services:

- Yes No **Licensed Hospital Beds/ Number** _____
- Yes No **Substance Abuse Services**
- Yes No **Mental Health Services**
- Yes No **OB/GYN Services**
- Yes No **Pediatrics**
- Yes No **Physical Rehabilitation**

BCBSNC HMO/PPO Managed Care Networks Only

- Birth Center**
- Private Duty Nursing Agency**
(All of the following services must be provided in order to meet contracting requirements)
 - R.N.
 - L.P.N.

- Hospice Agency**
Please check type of care:
 - Inpatient Beds, No. of Beds _____
 - Resident/Respite Beds, No. of Beds _____

- Residential Treatment Facility**

- Intensive Outpatient Facility**

Blue Medicare HMO/PPO Networks Only **Skilled Nursing Facility and/or Hospital with Skilled Nursing Beds**

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?

- Free Standing Radiology Facility**
- Specialty Pharmacy**

(Provider must meet **all three** of the following criteria in order to meet contracting requirements. Please indicate below if you meet the criteria)

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

- Provide these drugs directly to physicians
- Provide these drugs directly to Members

- Reference Laboratory
- Cardiac Event Monitoring
- Home Durable Medical Equipment (Cardiac Event Monitoring Equipment Only)
- Ambulance

- Independent Diagnostic Testing Facility
- Mobile X-ray
- Sleep Centers

Is your entity a Physician-owned facility? Yes No

If no, please describe the ownership _____

3. THE FOLLOWING PROVIDER TYPES ARE SUBJECT TO BCBSNC HMO/PPO MANAGED CARE NETWORKS CONTRACTING REQUIREMENTS RATHER THAN CREDENTIALING CRITERIA. PLEASE COMPLETE THE INFORMATION IN 3.D., 3.E AND 3.F. FOR *EACH* LOCATION LISTED. IF NECESSARY, PLEASE COPY THIS SECTION FOR EACH LOCATION:

Not Applicable for Blue Medicare HMO/PPO Networks

- A. Mobile Lithotripsy Provider
 - a. Complete Ancillary Application
 - b. Valid State License
 - c. Evidence of adequate malpractice coverage (General Liability), minimum of 1 million/3 million
 - d. W-9 Form
 - e. Provide list of physicians (name, address, UPIN)

- B. Reference Laboratory
 - a. Complete Ancillary Application
 - b. Current Accreditation CLIA
 - c. Evidence of adequate malpractice coverage (General Liability), minimum of 1 million/3 million
 - d. W-9 Form
 - e. Provide list of Pathologists (name, address, UPIN)

- C. **Specialty Pharmacy**
- a. **Complete Ancillary Application**
 - b. **Valid State License**
 - c. **Evidence of adequate malpractice coverage (General Liability), minimum of 1 million/3 million**
 - d. **W-9 Form**
 - e. **Other: Dispense drugs for the use of an individual member: Bill electronically on a HCFA 1500 w/HCPCS/CPT codes: Supply utilization reports**
 - f. **Provide list of physicians (name, address, UPIN)**

D. Application for Survey

If you have yet to complete an independent review of your operations, please attach a copy of your application for survey and letter with scheduled survey date from the accrediting organization, and describe the efforts you are undertaking to achieve accreditation.

E. Scope of Services

- a. For the most recent month, give number of patients served.
- b. For the most recent 12 months, give number of patients served.
- c. Indicate the full complement of services you provide by attaching a complete list of your services, billing codes and your usual and customary charges.
- d. Identify the top 30 services you provide based on volume.

F. Information on Operations and Staff

- a. List of professional staff positions, indicating level of education, and any certifications, and/or registrations achieved.
- b. Describe the continuing education programs you provide for your staff.
- c. Describe your patient intake process, including length of time from initial referral to time of service.
- d. Describe your patient education and follow up efforts.
- e. Describe the system you use to track patient complaints, and how you respond to complaints.
- f. Describe your reporting and paperwork delivery procedures and delivery times for utilization and case management.
- g. Please submit any reports you could share with us about items 3.F. a. - f.

4. 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 Plans 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.

We only accept the signature of the Authorized Representative of the Company.

Signature _____

Print Name: _____

Title: _____

Date: _____

Legal Contract Notice Information:

Name: _____

Title: _____

Organization: _____

Address: _____

This application was completed by:

Name: _____

Title: _____

Date: _____

Phone Number: _____

Facsimile Number: _____

Email: _____