

PROVIDER APPLICATION FOR PARTICIPATION

*Blue Cross Blue Shield of North Carolina and/or
PARTNERS National Health Plans of North Carolina, Inc.*

**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.*

1. PROVIDER INFORMATION

Initial Request Recredentialing

Please check which Plan you are applying for. Check both boxes if applying for both:

- Blue Cross and Blue Shield of North Carolina (BCBSNC)**
General Liability insurance of (1 mil/1 mil)
- PARTNERS National Health Plans, Inc. (PARTNERS)**
General Liability insurance of (1 mil/3 mil)

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

Yes No

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

Legal Name: _____

d/b/a Name: _____

Phone Number: (_____) _____ Facsimile Number (_____) _____

Street Address: _____

(No PO Box addresses)

Street Address

City	State	Zip	County
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Counties Served by this address: _____

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

Credentialing Contact Name: _____

Title: _____

Phone Number: _____

Email: _____

Remittance Address: (if different): _____

Street or PO Box

City	State	Zip	County
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(Complete Section 4. Provider Summary By Location for each site that uses the same remittance address and Tax ID number shown on this application.)

Does your organization submit claims electronically? Yes No

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:

BCBSNC and/or PARTNERS

Home Health Agency
(All of the following services must be provided in order to meet contracting requirements)

- 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)
 Comprehensive HIT (*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 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, # of Beds _____
 Resident/Respite Beds, # of Beds _____

Residential Treatment Facility

PARTNERS Only (Medicare Advantage)

Skilled Nursing Facility and/or Hospital with Skilled Nursing Beds

Free Standing Radiology Facility

Is Facility a Physician-owned facility? Yes No

If no, please describe the ownership _____

Free Standing Sleep Center

Is Facility a Physician-owned facility? Yes No

If no, please describe the ownership _____

Reference Laboratory

- Cardiac Event Monitoring
- Cardiac Event Monitoring (Equipment Only)
- Ambulance
- Independent Diagnostic Testing Facility
- Mobile X-ray

3. THE FOLLOWING PROVIDER TYPES ARE SUBJECT TO BCBSNC CONTRACTING REQUIREMENTS RATHER THAN CREDENTIALING CRITERIA. PLEASE COMPLETE THE INFORMATION IN 3.B., 3.C AND 3.D. FOR EACH LOCATION LISTED. IF NECESSARY, PLEASE COPY THIS SECTION FOR EACH LOCATION:

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

B. 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.

C. 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.

D. 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.

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 and/or PARTNERS Plans 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: _____