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 outlined on BCBSNC’s Provider Website for the credentialing criteria in order to complete the credentialing process.

You may also mail the completed form to:

Credentialing Department
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. 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:

<table>
<thead>
<tr>
<th>BCBSNC Managed Care Networks and Blue Medicare HMO and Blue Medicare PPO Networks</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Ambulatory Surgery Center</td>
</tr>
<tr>
<td>☐ Dialysis Facility</td>
</tr>
<tr>
<td>☐ HDME (Diabetic Supplies Only)</td>
</tr>
<tr>
<td>☐ HDME (Orthotics and Prosthetics)</td>
</tr>
<tr>
<td>☐ HDME (Breast Prosthesis Only)</td>
</tr>
<tr>
<td>☐ Reference Laboratory</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>BCBSNC Managed Care Networks Only</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Birthing Center</td>
</tr>
<tr>
<td>☐ Hospice Agency</td>
</tr>
<tr>
<td>☐ Intensive Outpatient Facility</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Blue Medicare HMO and Blue Medicare PPO Networks Only</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Ambulance</td>
</tr>
<tr>
<td>☐ Cardiac Event Monitoring</td>
</tr>
<tr>
<td>☐ Free Standing Radiology Facility</td>
</tr>
<tr>
<td>☐ Home Durable Medical Equipment (Cardiac Event Monitoring Equipment Only)</td>
</tr>
</tbody>
</table>

Provider Information

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

As it appears on W9: ☐ Mgmnt or ☐ Parent Company

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: _________________________

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

4. Tax Identification Number: _________________________

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

5. Contact person for questions about this form: _________________________

   Title: _________________________

   Contact person’s email: _________________________

   Contact person’s phone and fax: 
   Tel (____)________________
   Fax (____)________________

6. Remittance address: 
(if different) ____________________________

   Remittance City, State, Zip ____________________________
   County ___________________

   Remittance phone and fax: 
   Tel (____)________________
   Fax (____)________________

7. Counties served by this facility: ____________________________

   ____________________________
   ____________________________
   ____________________________

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

8. Does your organization submit claims electronically? □ Yes  □ No

9. Is your entity a Physician owned facility? □ Yes  □ No

   If no, please describe the ownership:

   __________________________________________________________________________

Accreditation and Certification

Please complete the section below for your specialty, including your accreditation or survey expiration date, if applicable. If you do not complete this section as required for your specialty, BCBSNC cannot offer you a contract.

Ambulance

Facility accreditation: □ Yes  □ No

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

_______________________________________________________________

Effective: ____________  Expires: ____________

Medicare # Part A: _______________ Part B: ____________________
<table>
<thead>
<tr>
<th>Ambulatory Surgical Center</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facility accreditation: ☐ Yes ☐ NO</td>
</tr>
<tr>
<td>If yes, please indicate which Accreditation body you are affiliated:</td>
</tr>
<tr>
<td>_________________________________</td>
</tr>
<tr>
<td>Effective: ____________ Expires: ____________</td>
</tr>
<tr>
<td>Medicare # Part A: ____________ Part B: ____________</td>
</tr>
<tr>
<td>If not Medicare certified, why? _______________________________</td>
</tr>
<tr>
<td>Medicaid # ___________________</td>
</tr>
<tr>
<td>If not Medicaid certified, why? _______________________________</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Birthing Center</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facility accreditation: ☐ Yes ☐ NO</td>
</tr>
<tr>
<td>If yes, please indicate which Accreditation body you are affiliated:</td>
</tr>
<tr>
<td>_________________________________</td>
</tr>
<tr>
<td>Effective: ____________ Expires: ____________</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Cardiac Event Monitoring</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facility accreditation: ☐ Yes ☐ NO</td>
</tr>
<tr>
<td>If yes, please indicate which Accreditation body you are affiliated:</td>
</tr>
<tr>
<td>_________________________________</td>
</tr>
<tr>
<td>Effective: ____________ Expires: ____________</td>
</tr>
<tr>
<td>Medicare # Part A:</td>
</tr>
<tr>
<td>-------------------</td>
</tr>
<tr>
<td>If not Medicare certified, why?</td>
</tr>
<tr>
<td>Medicaid #</td>
</tr>
<tr>
<td>If not Medicaid certified, why?</td>
</tr>
</tbody>
</table>

**Independent Diagnostic Testing Facility**

Facility accreditation: ☐Yes ☐NO

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

_______________________________________________________________

Effective: ____________ Expires: ____________

<table>
<thead>
<tr>
<th>Medicare # Part A:</th>
<th>Part B:</th>
</tr>
</thead>
<tbody>
<tr>
<td>If not Medicare certified, why?</td>
<td></td>
</tr>
<tr>
<td>Medicaid #</td>
<td></td>
</tr>
<tr>
<td>If not Medicaid certified, why?</td>
<td></td>
</tr>
</tbody>
</table>

**Dialysis Facility**

Facility accreditation: ☐Yes ☐NO

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

_______________________________________________________________

Effective: ____________ Expires: ____________

<table>
<thead>
<tr>
<th>Medicare # Part A:</th>
<th>Part B:</th>
</tr>
</thead>
<tbody>
<tr>
<td>If not Medicare certified, why?</td>
<td></td>
</tr>
<tr>
<td>Medicaid #</td>
<td></td>
</tr>
<tr>
<td>If not Medicaid certified, why?</td>
<td></td>
</tr>
</tbody>
</table>
**Durable Medical Equipment** (Diabetic Supplies Only)

The DME provider network for BCBSNC closed to new providers. The DME provider network for Blue Medicare HMO and Blue Medicare PPO are closed to new providers.

---

**Free Standing Radiology**

Facility accreditation: ☐Yes ☐NO

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

________________________________________________________________________

Effective: ____________ Expires: ____________

Medicare # Part A:_____________ Part B:_________________

If not Medicare certified, why? _______________________________

Medicaid # ___________________

If not Medicaid certified, why? _______________________________

---

**Home Durable Medical Equipment**

The DME provider network for BCBSNC closed to new providers. The DME provider network for Blue Medicare HMO and Blue Medicare PPO are closed to new providers.

---

**Home Durable Medical Equipment** (Equipment Only)

The DME provider network for BCBSNC closed to new providers. The DME provider network for Blue Medicare HMO and Blue Medicare PPO are closed to new providers.

---

**Home Durable Medical Equipment** (Cardiac Event Monitoring Equipment Only)

Facility accreditation: ☐Yes ☐NO

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

________________________________________________________________________
Effective: ____________ Expires: ____________

Medicare # Part A: ________________ Part B: ________________

If not Medicare certified, why? ____________________________________

Medicaid # ________________

If not Medicaid certified, why? ____________________________________

### 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

Facility accreditation: [ ] Yes [ ] No

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

_______________________________________________________________

Effective: ____________ Expires: ____________

Medicare # Part A: ________________ Part B: ________________

If not Medicare certified, why? ____________________________________

Medicaid # ________________

If not Medicaid certified, why? ____________________________________

### 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

Facility accreditation: [ ] Yes [ ] No
If yes, please indicate which Accreditation body you are affiliated:

_______________________________________________________________

Effective: ____________ Expires: ____________

Medicare # Part A:______________ Part B:______________

If not Medicare certified, why? _______________________________

Medicaid # ___________________

If not Medicaid certified, why? _______________________________

<table>
<thead>
<tr>
<th>Hospice Agency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Please indicate type of care:</td>
</tr>
<tr>
<td>[ ] □ Inpatient: number of beds _____ [ ] □ Resident/Respite: number of beds _____</td>
</tr>
</tbody>
</table>

Facility accreditation: [ ] Yes [ ] No

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

_______________________________________________________________

Effective: ____________ Expires: ____________

<table>
<thead>
<tr>
<th>Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facility accreditation: [ ] Yes [ ] No</td>
</tr>
</tbody>
</table>

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

_______________________________________________________________

Effective: ____________ Expires: ____________

Medicare # Part A:______________ Part B:______________
If not Medicare certified, why? _______________________________

Medicaid # ___________________

If not Medicaid certified, why? _______________________________

### Intensive Outpatient Facility

Facility accreditation: ☐ Yes ☐ NO

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

_______________________________________________________________

Effect: ____________ Expires: ____________

### Mobile X-ray

Facility accreditation: ☐ Yes ☐ NO

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

_______________________________________________________________

Effect: ____________ Expires: ____________

Medicare # Part A: ____________ Part B: ____________

If not Medicare certified, why? _______________________________

Medicaid # ___________________

If not Medicaid certified, why? _______________________________

### Orthotics and Prosthetics

The O&P provider network for BCBSNC closed to new providers effective 6/1/07. The O&P provider network for Blue Medicare HMO and Blue Medicare PPO are closed to new providers.

### Orthotics and Prosthetics (Breast Prosthetics Only)

The O&P provider network for BCBSNC closed to new providers effective 6/1/07. The O&P provider network for Blue Medicare HMO and Blue Medicare PPO are closed to new providers.

### 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.

Facility accreditation: [Yes] [NO]

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

______________________________________________________________

Effective: ____________ Expires: ____________

### Reference Laboratory

Medicare #: Part A: ____________  Part B: ____________

If not Medicare certified, why? ________________________________

Medicaid #: ____________

If not Medicaid certified, why? ________________________________

### Residential Treatment Facility

Facility accreditation: [Yes] [NO]

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

______________________________________________________________

Effective: ____________ Expires: ____________

### 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.
Sleep Center

Facility accreditation: □Yes □NO

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

Effective: ____________  Expires: ____________

Medicare # Part A: _______________ Part B: _______________

If not Medicare certified, why? ______________________________________

Medicaid # ___________________

If not Medicaid certified, why? ______________________________________

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 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

Facility accreditation: □Yes □NO

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

Medicare # Part A:______________ Part B:______________

If not Medicare certified, why? _______________________________

Medicaid # ___________________

If not Medicaid certified, why? _______________________________

**Attachment Checklist**

The legal name must be the same on all supporting documents.

**For All Facilities:**

- A copy of your current accreditation certificate
- If not required in BCBSNC Credentialing Criteria to have accreditation a copy of your most recent CMS review is needed
- 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
- A W9 Form.

The following list shows which type of identification number you should provide:

<table>
<thead>
<tr>
<th>Organization</th>
<th>Identification Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Corporation</td>
<td>Federal I.D. Number</td>
</tr>
<tr>
<td>Partnership</td>
<td>Federal I.D. Number</td>
</tr>
<tr>
<td>Sole Proprietorship</td>
<td>Social Security Number</td>
</tr>
<tr>
<td>Individual</td>
<td>Social Security Number</td>
</tr>
</tbody>
</table>

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.

**Ambulatory Surgical Center**

- A current copy of the Division of Health Service Regulation License

**Birthing Center**

- 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.

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Documentation Required</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Home Health</strong></td>
<td>- A current copy of the Division of Health Service Regulation License</td>
</tr>
<tr>
<td><strong>Home Infusion</strong></td>
<td>- A current copy of the Division of Health Service Regulation License and Board of Pharmacy Permit-Infusion Services Permit.</td>
</tr>
<tr>
<td><strong>Hospice</strong></td>
<td>- A current copy of the Division of Health Service Regulation License</td>
</tr>
<tr>
<td><strong>Hospital</strong></td>
<td>- A current copy of the Division of Health Service Regulation License</td>
</tr>
<tr>
<td><strong>Private Duty Nursing</strong></td>
<td>- A current copy of the Division of Health Service Regulation License</td>
</tr>
</tbody>
</table>
| **Skilled Nursing Facility** | - A current copy of the Division of Health Service Regulation License  
- A copy of your Supplier Letter (approval letter) from the NSC |
| **Home Durable Medical Equipment** | - 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. |
| **Durable Medical Equipment (Diabetic Supplies Only)** | - 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. |
| **Durable Medical Equipment (Equipment Only)** | - 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. |
| **Orthotics & Prosthetics**  | - 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. |
| **Cardiac Event Monitoring Equipment** | - 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. |
| **Dialysis Facility**        | - 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)  
  - *Hematocrit  
  - *Urea Kinetic Modeling (Kt/V)  
  - *Albumin  
  - *Hemoglobin |
**Mobile Lithotripsy Provider**
- ☐ Valid State License
- ☐ Evidence of adequate malpractice coverage (General Liability), minimum of $1 million/3 million
- ☐ Provide list of physicians (name, address, UPIN)

**Reference Laboratory**
- ☐ Current Accreditation CLIA
- ☐ Evidence of adequate malpractice coverage (General Liability), minimum of $1 million/3 million
- ☐ Provide list of Pathologists (name, address, UPIN)

---

**Other Information**

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 ☐

If you are not currently accredited, and 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.
We only accept a signature of the Authorized Representative of the company.

Signature: _________________________________

Printed Name: _________________________________

Title: _________________________________

Date: _________________________________

Legal Contract Notice Information:

Name: _________________________________

Title: _________________________________

Organization: _________________________________

Address: _________________________________

This application was completed by:

Name: _________________________________

Title: _________________________________

Date: _________________________________

Phone Number: _________________________________

Facsimile Number: _________________________________

Email: _________________________________