Provider Application for Participation

This application is to be used if you wish to become a participating provider facility with Blue Cross and Blue Shield of North Carolina (Blue Cross NC). This application is not a contract.

Please follow the applicable credentialing instructions outlined on Blue Cross NC’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 on 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 NC 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: _________________________________________________________
<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Blue Cross NC Managed Care Networks and Blue Medicare HMO and Blue Medicare PPO Networks</th>
<th>Blue Cross NC Managed Care Networks Only</th>
<th>Blue Medicare HMO and Blue Medicare PPO Networks Only</th>
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</thead>
<tbody>
<tr>
<td>□ Ambulatory Surgery Center</td>
<td>□ Home Durable Medical Equipment (HDME) Company</td>
<td>□ Birthing Center</td>
<td>□ Mobile X-ray</td>
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<tr>
<td>□ Dialysis Facility</td>
<td>□ Home Health Agency</td>
<td>□ Hospice Agency</td>
<td>□ Independent Diagnostic Testing Facility</td>
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<tr>
<td>□ HDME (Diabetic Supplies Only)</td>
<td>□ Home Infusion Therapy (HIT) Agency</td>
<td>□ Intensive Outpatient Facility</td>
<td>□ Sleep Centers</td>
</tr>
<tr>
<td>□ HDME (Orthotics and Prosthetics)</td>
<td>□ Specialty Pharmacy</td>
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<td>□ Reference Laboratory</td>
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<tr>
<td>□ HDME (Breast Prosthesis Only)</td>
<td>□ Skilled Nursing Facility and/or Hospital with Skilled Nursing Beds</td>
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<td>□ Hospital</td>
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</tbody>
</table>
Provider Information

1. Provider’s legal name: __________________________________________________________
   (As it appears on W-9)
   Physical street address: __________________________________________________________
   Suite/Building: _________________________________________________________________
   City, state, Zip: __________________________ County: _____________________________
   Phone and fax: Phone: ( ) __________________________ 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: __________________________________________ □ Mgmnt or □ Parent Company

5. Medicare number: Part A: ____________________________________________________
   Part B: ______________________________________________________________________
   (Please also provide a copy of your W-9)

6. Contact person for questions about this form: __________________________ Title:

7. Remittance address (if different): _____________________________________________
   Remittance city, state, Zip: _____________________________________________________
   County: ______________________________________________________________________
   Remittance phone and fax: Phone: ( ) __________________________ Fax: ( ) ______________________

8. Counties served by this facility: ________________________________________________
   (If additional space is needed please add a separate page)

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

10. Is your entity a physician–owned facility? □ Yes □ No

   If no, please describe the ownership: ____________________________________________
   ____________________________________________________________
   ____________________________________________________________
**Home Durable Medical Equipment**

(The Blue Cross NC 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
- ☐ Home Health Aide
- ☐ Physical Therapy
- ☐ Speech Therapy
- ☐ 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.

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**Specialty Pharmacy**

Please review Additional Business Requirements for Specialty Pharmacy on the Blue Cross NC website at [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 and infused)
☐ Provide these drugs directly to physicians
☐ Provide these drugs directly to members

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**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 Blue Cross NC with notice of any changes in the submitted information, which occur from time to time. I also agree to promptly provide Blue Cross NC 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: __________________________________________________________________

Legal Contract Notice Information:

Name: __________________________________________________________________
Title: __________________________________________________________________
Organization: ___________________________________________________________
Address: __________________________________________________________________

Credentialing Mailing Address:

Name of Person Completing Application: _______________________________________
Title: __________________________________________________________________
Address: __________________________________________________________________
Phone Number: ___________________________________________________________
Fax Number: _____________________________________________________________
Email: ___________________________________________________________________

1 Blue Cross NC offers Healthy Outcomes programs as a convenience to aid members in improving their health; results are not guaranteed. Blue Cross NC reserves the right to discontinue or change Healthy Outcomes programs at any time. The programs are educational in nature, and are intended to help members make informed decisions about their health, and to help members comply with their doctor’s plan of care. Decisions regarding care should be made with the advice of a doctor.

2 Blue Cross NC offers Health Line Blue as a convenience to you. Blue Cross NC contracts with Optum, an independent third party vendor, for the provision of Health Line Blue and is not liable in any way for goods or services received from Optum. Optum does not provide Blue Cross and Blue Shield products or services. Blue Cross NC reserves the right to discontinue or change Health Line Blue at any time. Decisions regarding your care should be made with the advice of your doctor. In the event of an emergency, call 911.

BLUE CROSS®, BLUE SHIELD®, the Cross and Shield symbols, and service marks are marks of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans. Blue Cross NC is an independent licensee of the Blue Cross and Blue Shield Association. Blue Cross NC Credentialing Form – Facilities 5/17, U13172, 5/17