BlueCross BlueShield of North Carolina

Visit us at **BlueCrossNC.com**

Facility Credentialing and Recredentialing Application

This credentialing/recredentialing application is to be used if you wish to become a participating facility or ancillary provider with Blue Cross and Blue Shield of North Carolina (Blue Cross NC). It is not a contract. This credentialing/recredentialing application is to be used if you would like to become or remain a participating provider.

The applicable credentialing criteria and instructions to complete the process are outlined on the Blue Cross NC provider website.

Please complete this form and return to us via email at **facilities@bcbsnc.com**.

Complete a separate application for:

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

Application Type

☐ Initial Credentialing Request ☐ Recredentialing

Please check all Networks you are applying for:

☐ Blue Cross NC Managed Care Networks (Commercial) ☐ 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 location change?

☐ Yes ☐ No

If yes, please provide the old and new addresses below:

Old address: _____

New address: _____

BlueCross BlueShield of North Carolina

Provider Type Please indicate the service type for which you are applying:

Networks: Blue Cross NC Managed Care Networks (Commercial) | Blue Medicare HMO | Blue Medicare PPO

- ☐ Ambulance
- ☐ Ambulatory Infusion Center
- ☐ Ambulatory Surgery Center
- ☐ Dialysis Facility
- ☐ Home Durable Medical Equipment (HDME) Company
- ☐ HDME (Breast Prosthesis Only)
- ☐ HDME (Diabetic Supplies Only)
- ☐ HDME (Orthotics and Prosthetics)
- ☐ Home Health Agency
- ☐ Home Infusion Therapy (HIT) Agency
- ☐ Hospital
- ☐ Independent Diagnostic Testing Facility
- ☐ Reference Laboratory
- ☐ Skilled Nursing Facility
- ☐ Specialty Pharmacy

Networks: Blue Cross NC Managed Care Networks Only (Commercial)

- ☐ Birthing Center
- ☐ Hospice Agency
- ☐ Private Duty Nursing Agency

Networks: Blue Medicare HMO | Blue Medicare PPO

- ☐ Cardiac Event Monitoring
- ☐ Free Standing Radiology Facility
- ☐ Mobile X-ray
- ☐ Sleep Center

BlueCross BlueShield of North Carolina

Behavioral Health Facilities

Networks: Blue Cross NC Managed Care Networks (Commercial) | Blue Medicare HMO | Blue Medicare PPO

☐ **Opioid Centers (State license must indicate the following category)**
.3600 Outpatient Opioid Treatment
Group NPI: _____

☐ **Partial Hospitalization (State license must indicate one or more of the following categories)**

◯ .1100 Partial Hospitalization for Individuals Who Are Acutely Mentally Ill
Group NPI: _____

◯ .4500 Substance Abuse Comprehensive Outpatient Treatment
Group NPI: _____

☐ **Intensive Outpatient Facility**

A. General Psychiatric IOP

◯ .5400 License for Day Activity for Individuals of All Disability Groups
Group NPI: _____

B. Substance Use Disorder IOP

◯ .4400 License for Substance Abuse Intensive Outpatient Program
Group NPI: _____

Networks: Blue Cross NC Managed Care Networks Only (Commercial Only)

☐ **Residential Treatment (Blue Cross NC only)**

A. Residential Treatment/Rehabilitation for Individuals with Substance Abuse Disorders

◯ .3400 License for Residential Treatment/Rehabilitation for Individuals with Substance Abuse Disorders
Group NPI: _____

B. Psychiatric Residential Treatment for Children and Adolescents

◯ .1900 License for Psychiatric Residential Treatment Facility for Children and Adolescents
Group NPI: _____

C. Psychiatric Residential Treatment for Adults

◯ .5600A License Supervised Living for Adults with Mental Illness
Group NPI: _____

☐ **Facility-Based Crisis Center (State license must indicate the following category)**
.5000 Facility-Based Crisis Service for Individuals of All Disability Groups
Group NPI: _____

☐ **Medically Monitored Inpatient Withdrawal Management (State license must indicate the following category)**
.3100 Non-Hospital Medical Detoxification – Individuals Who Are Substance Abusers
Group NPI: _____

BlueCross BlueShield of North Carolina

Provider Information Please complete the following information for the location being credentialed.

1. **Provider's Legal Name** (as it appears on a Form W-9)

2. **DBA** (Doing Business As)

3. **Physical Location of Facility**

   Street Address: _____

   Suite/Bldg: _____

   City: _____ State: _____ ZIP Code: _____

   County: _____ Telephone: _____ Fax: _____

4. **Type 2** (Group) NPI

5. **Tax Identification Number** *Please provide a copy of a current Form W-9*

   _____ ☐ Management ☐ Parent Company

6. **Medicare Number**

   Part A: _____ Part B: _____

7. **Remittance Address** (if different from physical location)

   Street Address: _____ Suite/Bldg: _____

   City: _____ State: _____ ZIP Code: _____

   County: _____ Telephone: _____ Fax: _____

   Email: _____

BlueCross BlueShield of North Carolina

Provider Information (continued) Please complete the following information for the location being credentialed.

8. **Counties served by this facility:**

9. **Does your organization submit claims electronically?**

☐ Yes ☐ No

10. **Is your entity a physician-owned facility?**

☐ Yes ☐ No

If not physician-owned, please describe the ownership:

If additional space is needed, please attach a separate sheet

Home Health Agency

All of the following services must be provided to meet contracting requirements. Please indicate each service that you provide:

☐ Home Health Aide ☐ Occupational Therapy ☐ Skilled Nursing Visits

☐ Medical Social Services ☐ Physical Therapy ☐ Speech Therapy

Home Infusion Therapy

All of the following services must be provided to meet contracting requirements. Please indicate each service that you provide:

☐ Nursing ☐ Pharmacy ☐ Supplies

Hospice Agency

Please indicate the type of services that you provide:

☐ Inpatient: Number of beds ☐ Resident/Respite: Number of beds

BlueCross BlueShield of North Carolina

Provider Information (continued) Please complete the following information for the location being credentialed.

Private Duty Nursing Agency

All of the following services must be provided to meet contracting requirements. Please indicate each service that you provide:

☐ R.N. ☐ L.P.N.

Specialty Pharmacy

Please review additional business requirements for Specialty Pharmacy on the Blue Cross NC website at **BlueCrossNC.com/Providers/Forms-Documents** under Forms and Documentation prior to completing this application.

Provider must meet all of the following criteria to meet contracting requirements.

Please check the criteria you meet below:

☐ Provides all Medicare Part B drugs (oral & infused)

☐ Provides these drugs directly to members

☐ Provides these drugs directly to physicians

☐ Has a URAC accredited dispensing location within NC

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

3. **Has your organization been named in any malpractice actions in the last five years?**

☐ Yes ☐ No

If you answered "Yes" to any of the above questions, 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.

For contracting inquiries, please call **1-800-777-1643** and select option 6.

BlueCross BlueShield of North Carolina

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. I also agree to promptly provide Blue Cross NC with additional information requested during the credentialing or recredentialing process. I understand 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.

To Be Signed by Authorized Representative of the Company

Signature: _____

Printed Name: _____

Title: _____

Date: _____

Legal Contract Notice Information

Name: _____

Title: _____

Organization: _____

Mailing Address: _____

Email: _____

Credentialing Contact Information

Name of Person Completing Application: _____

Title: _____

Mailing Address: _____

_____

Email: _____ Telephone: _____ Fax: _____