BCBSNC Provider Application for Participation

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:

BCBSNC Managed Care Networks and Blue Medicare HMO and Blue Medicare PPO Networks	
☐ Ambulatory Surgery Center	☐ Home Durable Medical Equipment Company
☐ Dialysis Facility	☐ Home Health Agency
☐ HDME (Diabetic Supplies Only)	☐ Home Infusion Therapy (HIT) Agency
☐ HDME (Orthotics and Prosthetics)	☐ Reference Laboratory
☐ HDME (Breast Prosthesis Only)	☐ Skilled Nursing Facility and/or Hospital with Skilled Nursing Beds
☐ Hospital	☐ Specialty Pharmacy
BCBSNC Managed Care Networks Only	
☐ Birthing Center	☐ Private Duty Nursing Agency
☐ Hospice Agency	☐ Residential Treatment Facility
☐ Intensive Outpatient Facility	
Blue Medicare HMO and Blue Medicare PPO Networks Only	
☐ Ambulance	☐ Mobile X-ray
☐ Cardiac Event Monitoring	☐ Independent Diagnostic Testing Facility
☐ Free Standing Radiology Facility	☐ Sleep Centers
☐ Home Durable Medical Equipment (Cardiac Event Monitoring Equipment Only)	

Provider Information

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

As it appears on W9:

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: _____ ☐ 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: _____
   Contact person's email: _____
   Contact person's phone and fax: Tel ( ) _____ Fax ( ) _____
7. Remittance address: (if different) _____
   Remittance City, State, Zip _____ County _____
   Remittance phone and fax: Tel ( ) _____ 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 BCBSNC 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 ☐ Speech Therapy ☐ Physical Therapy

☐ Home Health Aide ☐ 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.

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

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: _____

Credentialing Mailing Address:

Name of Person
Completing Application: _____
Title _____
Address: _____
Phone Number: _____
Facsimile Number: _____
Email: _____