Facility Credentialing Application for Participation

This credentialing application is to be used if you wish to become a participating facility or ancillary provider with Blue Cross NC. This credentialing application is not a contract.

The applicable credentialing criteria and instructions to complete the process are outlined here on Blue Cross NC's Provider Website.

Please complete this form and return to us via email at credentialing@bcbsnc or by fax at 919-765-7016.

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 Plans 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 address below -

Old Address:

____

New Address:

____

Provider Type

Please indicate service type for which you are applying:
Please see Appendix A if you are applying for a Behavioral Health Facility Type

NETWORKS Blue Cross NC Managed Care Networks Blue Medicare HMO Blue Medicare PPO	
Ambulance	Home Health Agency
Ambulatory Infusion Center	Home Infusion Therapy (HIT) Agency
Ambulatory Surgery Center	Hospital
Dialysis Facility	Independent Diagnostic Testing Facility
Home Durable Medical Equipment Company	Reference Laboratory
HDME (Diabetic Supplies Only)	Skilled Nursing Facility
HDME (Orthotics and Prosthetics)	Hospital with Skilled Nursing Beds
HDME (Breast Prosthesis Only)	Specialty Pharmacy

NETWORKS Blue Cross NC Managed Care Networks Only	
Birthing Center	Private Duty Nursing Agency
Hospice Agency	

NETWORKS Blue Medicare HMO Blue Medicare PPO	
Cardiac Event Monitoring	Mobile X-ray
Free Standing Radiology Facility	Sleep Center

Appendix A: Behavioral Health Facilities

NETWORKS
Blue Cross NC Managed Care Networks
Blue Medicare HMO
Blue Medicare PPO

Opioid Centers (State license must indicate one or more of the following categories)

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

4500 Substance Abuse Comprehensive Outpatient Treatment

Group NPI: ____

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

Residential Treatment Facility (State license must indicate one or more of the following categories)

1900 Psychiatric Residential Treatment for children and adolescents

3400 Residential Treatment for individuals with substance abuse disorders

Group NPI: ____

Intensive Outpatient Facility (State license must indicate one or more of the following categories)

4400 Substance Abuse Intensive Outpatient Program

Group NPI: ____

Provider Information

Please complete the following information for the location being credentialed.

1. Provider's Legal Name (as it appears on a W9)

   ____

2. DBA (Doing Business As)

   ____

3. Physical Location of Facility

   Street address ____

   Suite/Bldg ____

   City, State, Zip ____

   County ____

   Telephone ____________________ Fax ____________________

4. Type 2 (Group) NPI ____

5. Tax Identification Number ________________________________ Mgmnt Parent Company

Please provider a copy of a current W9

6. Medicare Number Part A____________________ Part B____________________
7. Remittance Address (if different from physical location)

   Street address ____

   Suite/Bldg ____

   City, State, Zip ____

   County ____

   Telephone ____________________ Fax ____________________

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

Pharmacy	Nursing	Supplies

Hospice Agency

Please indicate the type of care:

Inpatient: number of beds _____   Resident / Respite: number of beds _____

Private Duty Nursing Agency

All following services must be provided in order 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 www.bcbsnc.com/providers under Forms and Documentation prior to completing this application.

Provider must meet all three of the following criteria 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

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 5 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.

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: ________________________________ Phone: ________________________________

Fax: _________________________________