

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.com 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

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 _____ Mgmt Parent Company

Please provide 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:

Provides all Medicare Part B drugs (oral & infused)

Provides these drugs directly to physicians

Provides these drugs directly to members

Has a URAC accredited dispensing location with 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 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: _____