



Regence BlueShield of Idaho is an Independent
Licensee of the Blue Cross and Blue Shield Association

Regence BlueShield of Idaho Organizational Provider/Facility Credentialing/Recredentialing Application

Regence contracts with facilities to form provider networks essential for the delivery of health care services to our members.

Regence requires all organizational providers to meet criteria prior to contracting, and remain in compliance with criteria at all times. Please refer to the *Organizational Provider Credentialing Criteria for Participation and Termination* for details.

You will receive an email confirmation once you have passed successful credentialing. When your agreement documents are available online for viewing or signature you will receive another email. This email will contain instructions for accessing the online documents securely through the eContracting Center.

To begin the credentialing verification process, please:

1. Complete this application in its entirety using black or blue ink.
2. Provide the email address and name of the individual who is responsible for reviewing and electronically signing your agreement documents:

First Name:	
Last Name:	
Email:	

3. **Return completed applications to:**

Regence BlueShield of Idaho
Credentialing Department
PO Box 1106
Mail Stop LA1W
Lewiston, ID 83501

Fax: 1 (888) 335-3002

If you believe any information is erroneous, you may request a correction however; we have sole discretion over whether or not to make any changes.

To learn more about the credentialing process and eContracting, visit the Welcome Center at www.id.regence.com/physician/welcome. If you have questions about the process or the status of your application, please contact our Credentialing Department at 1 (888) 258-3435.

Copy this page, prior to completing, for additional offices.

Demographic/Location Information:

Please indicate the facility's main office, mailing, payment and contact information by completing the appropriate information and checking one or more address type.

Address #1 (choose both, if applicable) Primary Office Mailing

Facility/Organization Name (DBA): _____

NPI# _____ Effective Date: _____

Street Address: _____

City: _____ State: _____ Zip code: _____

Phone#: _____ Fax#: _____

Contact(s) at this address:

Contact Name: _____ Email Address: _____

Phone#: _____ Fax#: _____

Address #2 (choose both, if applicable) Primary Office Mailing

Facility/Organization Name (DBA): _____

NPI# _____ Effective Date: _____

Street Address: _____

City: _____ State: _____ Zip code: _____

Phone#: _____ Fax#: _____

Contact(s) at this address:

Contact Name: _____ Email Address: _____

Phone#: _____ Fax#: _____

Address #3 (choose both, if applicable) Primary Office Mailing

Facility/Organization Name (DBA): _____

NPI# _____ Effective Date: _____

Street Address: _____

City: _____ State: _____ Zip code: _____

Phone#: _____ Fax#: _____

Contact(s) at this address:

Contact Name: _____ Email Address: _____

Phone#: _____ Fax#: _____

Payment/Billing Information:

Reporting Name: _____
Corporate Name: _____
Tax ID Number: _____
Street Address: _____
City: _____ State: _____ Zip code: _____
Billing Contact Name: _____ Phone#: _____
Email Address: _____ Fax#: _____

Please provide a copy of the W-9 IRS form

Licensure/Certification/Accreditation:

State License Number: _____ Expiration Date: _____
Is the facility a participating Medicare provider? Yes No
Medicare Number: _____
Is the facility a participating Medicaid provider? Yes No
Medicaid Number: _____
Accrediting Organization: _____
Effective Date: _____ Expiration Date: _____

Please provide a copy of all licenses and certificates and your most recent Centers of Medicare and Medicaid (CMS) survey with any site visit corrections showing that your facility is in compliance.

Liability Insurance:

Insurance Carrier: _____ Phone#: _____
Policy#: _____ Dates of Coverage: _____
\$ Amount per Occurrence: _____ \$ Amount Aggregate: _____

Please provide a copy of your current professional and general liability insurance.

Ownership/Management Information:

President/CEO:
Name: _____
Title: _____ Phone#: _____
Chief Financial Officer (CFO):
Name: _____
Title: _____ Phone#: _____
Medical Director:
Name: _____
Title: _____ Phone#: _____

Ownership/Management Information (continued):

Other Managing Employees¹ or Persons with Ownership or Control Interest²:

Name: _____

Title: _____ Phone: _____

Name: _____

Title: _____ Phone: _____

Name: _____

Title: _____ Phone: _____

Attestation Questionnaire:

If any of the following questions are answered "Yes", please provide details on a separate sheet.

1. Yes No Has the facility ever had or currently have pending, any legal actions excluding medical malpractice?
2. Yes No Has the facility ever been convicted of a crime, excluding misdemeanors?
3. Yes No Has any government agency ever investigated, suspended, revoked, or taken other action against your license to conduct business?
4. Yes No At any time, has any license or certification ever been revoked, denied, or suspended by others or voluntarily given up by the facility, or are any actions which may lead to such conclusions now under way?
5. Yes No At any time, has the facility been assessed a penalty, conviction or suspension or is the facility currently under investigation by the Medicaid or Medicare programs?
6. Yes No At any time, has any third party payors ever revoked, reduced, denied, or suspended your facility's participation due to inappropriate utilization management or any quality of care issues?
7. Yes No Has any managing employee or person with an ownership or control interest been excluded from participation in a government program (e.g., Medicare, Medicaid)?

¹ "Managing employee" means "a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of an institution, organization, or agency."

² "A Person with an ownership or control interest" means "a person or corporation that—
(a) Has an ownership interest totaling 5 percent or more in a disclosing entity;
(b) Has an indirect ownership interest equal to 5 percent or more in a disclosing entity;
(c) Has a combination of direct and indirect ownership interests equal to 5 percent or more in a disclosing entity;
(d) Owns an interest of 5 percent or more in any mortgage, deed of trust, note, or other obligation secured by a disclosing entity if that interest equals at least 5 percent of the value of the property or assets of a disclosing entity;
(e) Is an officer or director of a disclosing entity that is organized as a corporation; or
(f) Is a partner in a disclosing entity that is organized as a partnership."

Staffing:

Does the facility validate the credentials for licensed practitioner employed or contracted at the facility? Yes No

If Yes, indicate how the facility conducts the credentialing process for each practitioner employed or contracted at the facility:

- Credentialing procedures are performed internally.
- Credentialing procedures are outsourced to: _____
- Other, specify: _____

If No, please explain: _____

Exclusion Certification:

I hereby certify that the on-line exclusion lists for the Health and Human Services, Office of Inspector General (OIG) and Excluded Parties List System (EPLS) are checked for all new hires and annually for existing employees to ensure that no excluded employees work on any jobs related to any Federal health care programs. I also hereby certify that I will remove any employee found on one of the above-referenced lists from any work related to a Federal health care program.

Authorized Signature for Facility

Date

Print Name

Title

Release of Information and Authorization:

I hereby certify that all responses and information provided pursuant to the above questions and requests are complete, accurate and current to the best of my knowledge and belief. I acknowledge that any misstatements in or omissions from this application constitute cause for denial or summary dismissal. Further, I give permission to verify the organizational providers credentials and by doing so hereby authorize release of the requested information concerning the organizational providers licensing, certification and accreditation. I warrant that I have the authority to sign this application on behalf of the entity for which I am signing in a representative capacity.

Authorized Signature for Facility

Date

Print Name

Title

TRICARE Conflict of Interest:

Federal law (5 U.S.C. 5536) prohibits medical personnel, who are active duty members or civilian employees of the government, compensation above their normal pay and allowances for medical care rendered. This prohibition applies to TRICARE benefits whether the claim for reimbursement is filed by the individual who provided the care, the facility in which the care was rendered, or by the sponsor/beneficiary. Claims for TRICARE benefits will be denied in any situation where either a uniform member or civilian employee of the uniform services has the opportunity to exert, directly or indirectly, any influence on the referral of TRICARE beneficiaries to one or more providers on a selective basis.

As part of the credentialing and contracting process, if the provider has included any information that they are an Active Duty Service Member (ADSM), they are not eligible to bill TRICARE for any services provided inside or outside of the Military Treatment Facility. These providers should not be contracted as a network provider. Provider agreements for ADSMs that are currently contracted as a network provider should be terminated.

Authorized Signature for Facility

Date

Print Name

Title

Hospital/Facility Services/Capability

Date: _____

Provider Name: _____

Physical Address: _____

City, State, Zip code: _____

Please check the services that are available at your hospital/facility. These may or may not be a covered benefit.

<input type="checkbox"/> Acute Care <input type="checkbox"/> Air Ambulance <input type="checkbox"/> Alcohol/Chem Dep Adol. Detox <input type="checkbox"/> Alcohol/Chem Dep Adol Outpatient <input type="checkbox"/> Alcohol/Chem Dep Adol PHP <input type="checkbox"/> Alcohol/Chem Dep Adol Rehab <input type="checkbox"/> Alcohol/Chem Dep Adult Detox <input type="checkbox"/> Alcohol/Chem Dep Adult Outpatient <input type="checkbox"/> Alcohol/Chem Dep Adult PHP <input type="checkbox"/> Alcohol/Chem Dep Adult Rehab <input type="checkbox"/> Ambulance Services <input type="checkbox"/> Audiology <input type="checkbox"/> Behavioral Health <input type="checkbox"/> Birthing Rooms <input type="checkbox"/> Blood Bank <input type="checkbox"/> Burn Unit <input type="checkbox"/> Cancer <input type="checkbox"/> Cardiac <input type="checkbox"/> Cochlear Implant Surgery <input type="checkbox"/> CT Scanner <input type="checkbox"/> Diabetes Education <input type="checkbox"/> Dialysis - Outpatient <input type="checkbox"/> EEG Monitoring <input type="checkbox"/> Emergency Room <input type="checkbox"/> Gamma Knife <input type="checkbox"/> Geriatric Services <input type="checkbox"/> Home Health * <input type="checkbox"/> Home Infusion * <input type="checkbox"/> Hospice Care <input type="checkbox"/> Hyperbaric Treatment <input type="checkbox"/> ICU <input type="checkbox"/> IOP <input type="checkbox"/> Lab-Outpatient <input type="checkbox"/> Lithotripsy <input type="checkbox"/> Mammography <input type="checkbox"/> Maternity <input type="checkbox"/> MRA <input type="checkbox"/> MRI <input type="checkbox"/> Neonatal ICU Level 1 <input type="checkbox"/> Neonatal ICU Level 2 <input type="checkbox"/> Neonatal ICU Level 3	<input type="checkbox"/> Neurology <input type="checkbox"/> Nuclear Medicine <input type="checkbox"/> Nursery <input type="checkbox"/> Obstetrics <input type="checkbox"/> Occupational Therapy Inpatient <input type="checkbox"/> Occupational Therapy IP/OP <input type="checkbox"/> Occupational Therapy Outpatient <input type="checkbox"/> Oncology <input type="checkbox"/> Open Heart Surgery <input type="checkbox"/> Orthopedics <input type="checkbox"/> Outpatient Surgery <input type="checkbox"/> Pain Management <input type="checkbox"/> Partial Hospitalization <input type="checkbox"/> Pediatric Emergency Care <input type="checkbox"/> Pediatric Hematology Oncology <input type="checkbox"/> Pediatric ICU <input type="checkbox"/> Pediatric Physical Therapy <input type="checkbox"/> Pediatric Rehabilitation <input type="checkbox"/> Pediatrics <input type="checkbox"/> PET Scan <input type="checkbox"/> Physical Therapy Inpatient <input type="checkbox"/> Physical Therapy IP/OP <input type="checkbox"/> Physical Therapy Outpatient <input type="checkbox"/> Psych Unit * <input type="checkbox"/> Psych Svcs – Adol Eating Disorder <input type="checkbox"/> Psych Svcs – Adol Inpatient <input type="checkbox"/> Psych Svcs – Adol Outpatient <input type="checkbox"/> Psych Svcs – Adol PHP <input type="checkbox"/> Psych Svcs – Adult Inpatient <input type="checkbox"/> Psych Svcs – Adult Outpatient <input type="checkbox"/> Psych Svcs – Adult PHP <input type="checkbox"/> Psych Svcs – Child Inpatient <input type="checkbox"/> Radiation Center <input type="checkbox"/> Radiation Oncology <input type="checkbox"/> Rehab Unit * <input type="checkbox"/> Skilled Nursing Unit * <input type="checkbox"/> Sleep Studies <input type="checkbox"/> Speech Therapy Inpatient <input type="checkbox"/> Speech Therapy IP/OP <input type="checkbox"/> Speech Therapy Outpatient <input type="checkbox"/> Sports Medicine	<input type="checkbox"/> Swing Bed * <input type="checkbox"/> Transplant-Bone Marrow <input type="checkbox"/> Transplant-Cornea <input type="checkbox"/> Transplant-Heart <input type="checkbox"/> Transplant-Heart/Lung <input type="checkbox"/> Transplant-Kidney <input type="checkbox"/> Transplant-Liver <input type="checkbox"/> Transplant-Liver-Kidney <input type="checkbox"/> Transplant-Pancreas/Kidney <input type="checkbox"/> Transplant-Small Intestine <input type="checkbox"/> Transplant-Small Intestine/Liver <input type="checkbox"/> Transplant-Tissue <input type="checkbox"/> Trauma Level 1 <input type="checkbox"/> Trauma Level 2 <input type="checkbox"/> Trauma Level 3 <input type="checkbox"/> Trauma Level 4 <input type="checkbox"/> Trauma Level 5 <input type="checkbox"/> Traumatic Brain Injury <input type="checkbox"/> Ultra Sound <input type="checkbox"/> Urgent Care <input type="checkbox"/> Ventilator Care
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* If these services are separately Medicare Certified please identify.

Durable Medical Equipment Services/Capability

Date: _____

Provider Name: _____

Physical Address: _____

City, State, Zip code: _____

Please check the services that are available at your hospital/facility. These may or may not be a covered benefit.

- | | |
|--|--|
| <input type="checkbox"/> Air Mattress | <input type="checkbox"/> Jazzy Wheelchair |
| <input type="checkbox"/> Augmentative Device | <input type="checkbox"/> Medical Equipment and Repairs |
| <input type="checkbox"/> Bath Chair | <input type="checkbox"/> Medical Supplies |
| <input type="checkbox"/> Breast Pumps | <input type="checkbox"/> Orbital Prosthesis |
| <input type="checkbox"/> Chest Compression Apparatus/Cystic Fibrosis | <input type="checkbox"/> Orthotics |
| <input type="checkbox"/> Commodes | <input type="checkbox"/> Parenteral |
| <input type="checkbox"/> Computer Software | <input type="checkbox"/> Prosthetics |
| <input type="checkbox"/> CPM Machine | <input type="checkbox"/> Pulse Oximeter |
| <input type="checkbox"/> Easy Stander | <input type="checkbox"/> Respiratory |
| <input type="checkbox"/> Enteral | <input type="checkbox"/> Respite Care |
| <input type="checkbox"/> EZ Lock Wheelchair | <input type="checkbox"/> Restrain System |
| <input type="checkbox"/> Feeding Pumps | <input type="checkbox"/> RT-300 Ergometer Cycle |
| <input type="checkbox"/> Grab Bars | <input type="checkbox"/> Specialized Beds |
| <input type="checkbox"/> Hand Control for Vehicle | <input type="checkbox"/> Specialized Wheelchair Custom |
| <input type="checkbox"/> Hearing Aids | <input type="checkbox"/> Specialized Wheelchair Manual |
| <input type="checkbox"/> Home Care | <input type="checkbox"/> TPN |
| <input type="checkbox"/> Infusion Pumps | <input type="checkbox"/> Van Lift |
| <input type="checkbox"/> Infusion Therapy – Adult | <input type="checkbox"/> Walker |
| <input type="checkbox"/> Infusion Therapy – Pediatric | <input type="checkbox"/> Wheelchair Lift Car |
| <input type="checkbox"/> Insulin Pump | |

Skilled Nursing Facility Services/Capability

Date: _____

Provider Name: _____

Physical Address: _____

City, State, Zip code: _____

Please check the services that are available at your hospital/facility. These may or may not be a covered benefit.

<input type="checkbox"/> Behavioral Health Dual Diagnosis	<input type="checkbox"/> Post Hospitalization
<input type="checkbox"/> Cardiac Rehab	<input type="checkbox"/> Post Transplant
<input type="checkbox"/> Cardio Drips	<input type="checkbox"/> Residential Care
<input type="checkbox"/> Hemo Dialysis	<input type="checkbox"/> Specialized/Complex Wound Care
<input type="checkbox"/> Hyperbaric Treatment	<input type="checkbox"/> Specialty Beds (Types)
<input type="checkbox"/> IV Administration	<input type="checkbox"/> Speech Therapy Inpatient
<input type="checkbox"/> Levels of Care	<input type="checkbox"/> Speech Therapy IP/OP
<input type="checkbox"/> Neurology Services	<input type="checkbox"/> Speech Therapy Outpatient
<input type="checkbox"/> Occupational Therapy Inpatient	<input type="checkbox"/> Suction Therapy
<input type="checkbox"/> Occupational Therapy IP/OP	<input type="checkbox"/> Trachs
<input type="checkbox"/> Occupational Therapy Outpatient	<input type="checkbox"/> Transportation
<input type="checkbox"/> Orthopedic Services	<input type="checkbox"/> Traumatic Brain Injury
<input type="checkbox"/> Ostomy Care	<input type="checkbox"/> Vents
<input type="checkbox"/> Oxygen Therapy	<input type="checkbox"/> Wound Care
<input type="checkbox"/> Pediatric Vents	<input type="checkbox"/> Wound Vac
<input type="checkbox"/> Pediatrics	
<input type="checkbox"/> Physical Therapy Inpatient	
<input type="checkbox"/> Physical Therapy IP/OP	
<input type="checkbox"/> Physical Therapy Outpatient	

Radiology Center Services/Capability

Date: _____

Provider Name: _____

Physical Address: _____

City, State, Zip code: _____

Please check the services that are available at your hospital/facility. These may or may not be a covered benefit.

<input type="checkbox"/> Bone Scan	<input type="checkbox"/> MRI
<input type="checkbox"/> CT Scan	<input type="checkbox"/> Nuclear Medicine
<input type="checkbox"/> DEXA Scan	<input type="checkbox"/> PET Scan
<input type="checkbox"/> Mammography	<input type="checkbox"/> Radiation Therapy
<input type="checkbox"/> MRA	<input type="checkbox"/> Ultrasound