Practitioner Credentialing Application

Instructions: Read all instructions carefully prior to submitting your application. Claims should not be submitted until you receive notification of an approved application.

Tips to avoid delays: Complete only this application. Do not use another insurance plan's application. If handwritten, use a blue or black ink ball-point pen only. Do not use pencil. Print legibly. Complete all sections that are applicable to you. Include all additional information requested. Fields that include an asterisk (*) indicate that a response is required. All other fields will be considered not applicable if left blank.

If you have any questions, please call 800-756-2749 or send an email to prov.net@bcbsnd.com.

Section 1: Personal Information *(Note: BCBSND may use this method for application follow-up)*

Name *(Do not use nicknames or initials, unless they are part of your legal name)*

Last Name*	First Name*	Middle Name	Suffix

Credential*

Have you ever used another name? ☐ Yes ☐ No

If yes, please list all other names used and their dates of use		Dates other name was used	
Other Last Name	Other First Name	Date Started	End Date

Gender* ☐ Male ☐ Female ☐ Other/Non-binary

Date of Birth *(MM/DD/YYYY)**	SSN *(XXX-XX-XXXX)**

General Information

Only enter a Foreign National Identification Number if you do not have an SSN. *(Note: BCBSND may use email, phone, or fax for application follow-up)*

National Provider Identification (NPI) Number	Primary Specialty/Taxonomy

Languages Spoken

Home Address

Street	City	State	9-Digit Zip

Email*	Phone*	Fax*

Section 2: Professional IDs

Include all state licenses, DEA Registrations and SAMHSA waivers. If not applicable, put N/A.

IMPORTANT: DEA registration should match the state in which you work. Provide all current and previous licenses/certifications.

Federal DEA Number*

SAMHSA DEA Number*	State of Registration

DEA Issue Date *(MM/DD/YYYY)*	DEA Expiration Date *(MM/DD/YYYY)*

License Number*	License Issuing State*

License Issue Date *(MM/DD/YYYY)**	License Expiration Date *(MM/DD/YYYY)**

29380111 • 5-21

Section 2: Professional IDs *(Continued)*

Are you currently practicing in this state?* ☐ Yes ☐ No

License Number	License Issuing State
License Issue Date *(MM/DD/YYYY)*	License Expiration Date *(MM/DD/YYYY)*

Are you currently practicing in this state? ☐ Yes ☐ No

License Number	License Issuing State
License Issue Date *(MM/DD/YYYY)*	License Expiration Date *(MM/DD/YYYY)*

Are you currently practicing in this state? ☐ Yes ☐ No

Other ID Numbers *(Note: Healthy Steps providers must be enrolled with Medicaid)*

Are you a participating Medicare provider? ☐ Yes ☐ No	Medicare Number	
Are you a participating Medicaid provider?* ☐ Yes ☐ No	Medicaid Number	Medicaid State
ECFMG Number *(Non-U.S./Canadian Graduate Only)*	ECFMG Certificate Issue Date *(MM/DD/YYYY)*	
Non-U.S. or Canadian School Name	Degree Awarded	
Non-U.S. or Canadian School Address	Date of Completion *(MM/DD/YYYY)*	
City	State	Country Code

Section 3: Education and Training

Provide the name of the school that issued your highest degree achieved. Graduation date is also required. Fifth Pathway information is needed for non-US/Canadian graduates.

Name of U.S., Canadian or Fifth Pathway Institution*	Degree Issued*	
Start Date *(MM/DD/YYYY)*	Graduation Date *(MM/DD/YYYY)**	
Street Address		
City	State	Zip

☐ U.S. or Canadian Graduate
☐ Non-U.S./Canadian Graduate *(See other ID section above)*
☐ Fifth Pathway Graduate *(See other ID section above)*

Training

List post-graduate training programs you attended. Use one section per institution. Please explain in Section 5, any post-graduate training gaps of three months or greater. Residency institution and completion date required for MD or DO degree.

Institution/Hospital Name		
Street Address		
City	State	Zip

29380111 • 5-21

Section 3: Education and Training *(Continued)*

Phone	Fax	
☐ Fellowship ☐ Internship ☐ Residency	Start Date *(MM/DD/YYYY)*	Completion Date *(MM/DD/YYYY)*
Institution/Hospital Name		
Street Address		
City	State	Zip
Phone	Fax	
☐ Fellowship ☐ Internship ☐ Residency	Start Date *(MM/DD/YYYY)*	Completion Date *(MM/DD/YYYY)*
Institution/Hospital Name		
Street Address		
City	State	Zip
Phone	Fax	
☐ Fellowship ☐ Internship ☐ Residency	Start Date *(MM/DD/YYYY)*	Completion Date *(MM/DD/YYYY)*

Section 4: Work History

Include a chronological work history for the past 5 years. Current position appears in Section 6. If graduation date was less than 5 years ago, any work history from that date forward is sufficient. **If there are any gaps in your work history, please explain at the bottom of this section.**

Practice Employer Name			
Street Address			
City	State	Zip	
Phone	Fax	Start Date	End Date
Practice Employer Name			
Street Address			
City	State	Zip	
Phone	Fax	Start Date	End Date

29380111 • 5-21

Section 4: Work History *(Continued)*

Practice Employer Name			
Street Address			
City	State	Zip	
Phone	Fax	Start Date	End Date

Section 5: Work History Details

Provide information on any gaps in your work history and include timeframes in month/year format.

Section 6: Practice Location and Specialty Information

TIP: Your Individual Tax ID is assumed to be your Primary Tax ID unless you specify otherwise to the right. Billing NPI refers to the NPI that would be placed in Box 33a on a paper CMS 1500 claim form.

IMPORTANT: Include a copy of your W-9 for each Tax ID referenced in this application.

Provide either an individual SSN or Group/Federal Tax ID for your primary practice

Individual Tax ID *(SSN) (XXX-XX-XXXX)* | Group/Federal Tax ID *(XX-XXXXXXX)*

Billing NPI that will be Submitted on Claims

List Languages Spoken by Office Staff

Are Interpreters Available? ☐ Yes ☐ No

Is the Location Listed Below Handicap Accessible? ☐ Yes ☐ No

Are You Currently Practicing at the Address Below? ☐ Yes ☐ No

Start Date *(MM/DD/YYYY)*	Age Range of Patients Accepted	
Primary Practicing Specialty at this Location		Display in Directory ☐ Yes ☐ No

Board Certified Specialty? ☐ Yes ☐ No

Name of Certification Board

Initial Certification Date *(MM/DD/YYYY)*	Recertification Date *(MM/DD/YYYY)*	Expiration Date *(MM/DD/YYYY)*

Currently Accepting New Patients?* ☐ Yes ☐ No

Physician/Group Practice Name to Appear in Directory *(Do not abbreviate)*

Group/Corporate Legal Name as it Appears on W-9 *(If different from above. Do not abbreviate)*

Does Business/Corporation have an existing agreement with BCBSND? ☐ Yes ☐ No ☐ Unsure

Website Address *(URL)*

Practice Street Address

City	State	9-Digit Zip
Appointment Phone	Business Fax	Website URL

Mailing Address *(If different than above)*

City	State	Zip

Check Address

City	State	Zip

Section 6: Practice Location and Specialty Information *(Continued)*

Credentialing Contact Name	Email
Credentialing Mailing Address	Phone
City / State / Zip	

Additional Practice Location 1

List additional location that uses SAME TAX ID as listed above that you wish to have listed in BCBSND provider directory (will only be listed if directory display = Yes). Billing NPI refers to the NPI that would be placed in Box 33a on a paper CMS 1500 claim form (or corresponding electronic field). If more space is needed include additional documentation as an attachment.

Start Date *(MM/DD/YYYY)*	Primary Practicing Specialty at this Location
Display in Directory ☐ Yes ☐ No	Billing NPI that will be Submitted on Claims

Currently Accepting New Patients? ☐ Yes ☐ No

Physician/Group Practice Name to Appear in Directory *(Do not abbreviate)*

Group/Corporate Legal Name as it Appears on W-9 *(If different from above. Do not abbreviate)*

Does Business/Corporation have an existing agreement with BCBSND? ☐ Yes ☐ No ☐ Unsure

Practice Street Address

City	State	9-Digit Zip
Appointment Phone	Business Fax	Contact Email

Mailing Address *(If different from above)*

City	State	Zip

Check Address *(If different from above)*

City	State	Zip

Additional Practice Location 2

Start Date *(MM/DD/YYYY)*	Primary Practicing Specialty at this Location
Display in Directory ☐ Yes ☐ No	Billing NPI that will be Submitted on Claims

Currently Accepting New Patients?* ☐ Yes ☐ No

Physician/Group Practice Name to Appear in Directory *(Do not abbreviate)*

Group/Corporate Legal Name as it Appears on W-9 *(If different from above. Do not abbreviate)*

Does Business/Corporation have an existing agreement with BCBSND? ☐ Yes ☐ No ☐ Unsure

Section 6: Practice Location and Specialty Information *(Continued)*

Practice Street Address		
City	State	9-Digit Zip
Appointment Phone	Business Fax	Contact Email
Mailing Address *(If different from above)*		
City	State	Zip
Check Address *(If different from above)*		
City	State	Zip

Section 7: Admitting Privileges

List all current hospitals/institutions for which you have admitting privileges. If none, check "N/A."

Name of Hospital/Institution ☐ N/A		Date Admitting Privileges were Granted *(MM/DD/YYYY)*
Street Address		
City	State	Zip
Name of Hospital/Institution ☐ N/A		Date Admitting Privileges were Granted *(MM/DD/YYYY)*
Street Address		
City	State	Zip

Section 8: Disclosure Questions

Answer all questions. If a question does not apply, answer "No." **Provide a detailed explanation for any "Yes" answers to the questions below.** Attach additional documentation if necessary.

1	Do you currently have any physical impairment or disability that could, without reasonable accommodation, impede your ability to provide care according to accepted standards of professional performance or poses a threat to the health or safety of your patients?*	☐ Yes ☐ No
2	Do you currently have any mental impairment or disability that could, without reasonable accommodation, impede your ability to provide care according to accepted standards of professional performance or poses a threat to the health or safety of your patients?*	☐ Yes ☐ No
3	Do you currently have any substance abuse problems that could, without reasonable accommodation, impede your ability to provide care according to accepted standards of professional performance or poses a threat to the health or safety of your patients?*	☐ Yes ☐ No
4	Have you received treatment for substance abuse related conditions in the past five years?*	☐ Yes ☐ No
5	Have you ever been convicted of a felony, fraud, narcotics offense, moral, or any other type of ethical crime?*	☐ Yes ☐ No
6	Has your license or certification to practice in any jurisdiction ever been limited, restricted, revoked, suspended, voluntarily relinquished, terminated, subjected to disciplinary action or otherwise acted upon in an adverse manner?*	☐ Yes ☐ No
7	Have you ever been sanctioned or penalized by any hospital, licensing board, government entity or managed care organization?*	☐ Yes ☐ No
8	Have you ever voluntarily or involuntarily refused or denied membership on a hospital medical staff?*	☐ Yes ☐ No

Section 9: Disclosure Questions *(Continued)*		
9	Have your specific clinical privileges at a facility in any jurisdiction ever been denied, limited, suspended, diminished, revoked, withdrawn or denied renewal?*	☐ Yes ☐ No
10	Have you ever been subjected to disciplinary action by any medical organization?*	☐ Yes ☐ No
11	Have you ever been subjected to any claim(s) or under investigation for unethical conduct?*	☐ Yes ☐ No
12	Have you ever been the subject of a malpractice claim or are there currently pending malpractice claims, suits, settlements, arbitration proceedings, or complaints filed involving your professional practice? If yes, attach a copy of the claim(s).*	☐ Yes ☐ No
13	Have any judgments been made against you or settlements by you in any malpractice claim?*	☐ Yes ☐ No
14	Have you ever been denied liability insurance, in whole or in part, or has your policy ever been canceled, involuntarily restricted, denied renewal, or rated up because of the nature of volume of claims against you?*	☐ Yes ☐ No
15	Has your DEA or state certificate controlled dangerous substance license ever been suspended or revoked?*	☐ Yes ☐ No

Section 10: Disclosure Question Details

Disclosure Questions answered "Yes" require additional information for review during the Credentialing process. Please provide the question number along with as much detail as possible or attach documentation.

Section 11: Additional Directory Location – If Tax ID is different from locations listed in Section 4

List additional practice location for directory. Billing NPI refers to the NPI that would be placed in Box 33a on a paper CMS 1500 claim form (or corresponding electronic field).

IMPORTANT: Include a copy of your W-9 for each Tax ID referenced in this application.

Individual Tax ID *(SSN) (XXX-XX-XXXX)*	Group/Federal Tax ID *(XX-XXXXXXX)*	Use: ☐ Individual ☐ Group
Billing NPI that will be Submitted on Claims		
List Languages Spoken by Office Staff		
Are Interpreters Available? ☐ Yes ☐ No		
Is the Location Listed Below Handicap Accessible? ☐ Yes ☐ No		
Are You Currently Practicing at the Address Below? ☐ Yes ☐ No		
Start Date *(MM/DD/YYYY)*	Age Range of Patients Accepted	Currently Accepting New Patients?* ☐ Yes ☐ No
Primary Practicing Specialty at this Location		
Display in Directory? ☐ Yes ☐ No		Board Certified Specialty? ☐ Yes ☐ No
Name of Certification Board		
Initial Certification Date *(MM/DD/YYYY)*	Recertification Date *(MM/DD/YYYY)*	Expiration Date *(MM/DD/YYYY)*
Physician/Group Practice Name to Appear in Directory *(Do Not Abbreviate)*		
Group/Corporate Legal Name as it Appears on W-9 *(If different from above. Do not abbreviate)*		
Does Business/Corporation have an existing agreement with BCBSND? ☐ Yes ☐ No ☐ Unsure		
Website Address *(URL)*		
Practice Street Address		
City	State	9-Digit Zip
Appointment Phone	Business Fax	Website URL
Mailing Address *(If different than practice street address)*		
City	State	Zip
Check Address		
City	State	Zip

Section 12: Behavioral Health Providers Capability/Services

Capabilities *(Please check those capabilities in which you are certified or have received specific or on-going training. These may or may not be a covered benefit)*

☐ ADD/ADHD	☐ Dual Diagnosis	☐ Parenting Skills
☐ Addictions	☐ Eating Disorders	☐ Pastoral Counseling
☐ Adoption Issues	☐ Electro-Convulsive Therapy (ECT)	☐ Personality Disorder
☐ Anger Management	☐ Faith Based Counseling	☐ Pervasive Development Disorders
☐ Anxiety Disorder	☐ Family Therapy	☐ Phobias
☐ Applied Behavior Analysis	☐ Forensic/Sex Offenders	☐ Physical abuse/violence
☐ Asperger's Syndrome	☐ Gay/Lesbian Identified Children	☐ Physically impaired patients
☐ Autism	☐ Grief Counseling	☐ Play therapy
☐ Behavior Modification	☐ Group Therapy	☐ Police personnel
☐ Bi-Polar Disorder	☐ Head Injury Patients	☐ Post Partum Depression
☐ Biofeedback	☐ Hearing Impaired issues	☐ Post Traumatic Stress Disorder
☐ Child Abuse	☐ HIV Positive/AIDS Patients	☐ Psych. Disability Eval/Mgmt
☐ Christian Counseling	☐ Home Care/Home Visits	☐ Psychological Testing
☐ Chronic Mental Illness	☐ Hypnosis	☐ Psychosomatic
☐ Chronic Physical Illness	☐ Independent Qualified/Medical Ex	☐ Psychotic Disorders
☐ Co-dependency	☐ Infertility	☐ Rape Issues
☐ Cognitive Behavioral Therapy	☐ Inpatient Therapy	☐ Rape Victims
☐ Compulsive Gambling	☐ Learning Disabilities	☐ Schizophrenic Disorders
☐ Conduct/Disruptive Disorders	☐ Medical Stress/Behavioral Med	☐ Sex Offender
☐ Couples/Marriage Therapy	☐ Medication Management	☐ Sexual abuse/violence
☐ Crisis Diversionary Services	☐ Men's Issues	☐ Sexual Dysfunction
☐ Crisis Intervention Svcs	☐ Mood disorders	☐ Sexual Harassment
☐ Critical Incident Debriefing	☐ Multicultural Issues	☐ Sexual Identity Issues
☐ Depressive Disorder	☐ Neuropsych Assessment	☐ Sleep Disorders
☐ Developmental Disabilities	☐ Nursing Home Visits	☐ Somatoform Disorders
☐ Dialectical Behavioral Therapy	☐ Obesity Assessment/Counseling	☐ Substance Abuse
☐ Disability Evaluation	☐ Obsessive Compulsive Disorder	☐ Terminally Ill patients
☐ Dissociative Disorder	☐ Organic Brain Syndrome	☐ Visually Impaired patients
☐ Divorce	☐ Pain Management	☐ Weapons Clearance
☐ Domestic Violence	☐ Panic Disorder	☐ Women's Issues

Section 13: Professional Liability/Malpractice Insurance Carrier

Attach a current copy of malpractice/liability insurance certificate which includes the following: practitioner name, policy name, policy number, coverage dates, coverage amounts. **Credentialling application cannot be processed without this attachment.**

Section 14: Consent to the Inspection of Records and Documents Release of Information and Liability Certification/Attestation

I, _____ (print name*) hereby authorize BLUE CROSS BLUE SHIELD OF NORTH DAKOTA (BCBSND), its professional staff and legal representatives, to contact and consult with administrators and members of the professional staff of any treatment facility, institution, professional society, school, employer, law enforcement agency, or practice with which I have been associated, for the purpose of evaluating my professional competence, character, criminal history and ethical conduct. In addition, I consent to the inspection of all records and documents, including health records at other treatment facilities that may be material for evaluation of my professional qualifications by BCBSND, its professional staff and legal representatives. I release from liability all individuals or organizations for acts performed in good faith and without malice honestly initiated and in response to the inquiries authorized for use by BCBSND. I agree that a photocopy of this authorization may be accepted with the same authority as the original.

I certify and attest to the fact that all of the information I have submitted in this application is true and accurate to the best of my knowledge and belief.

Signature	Date *(MM/DD/YYYY)*

Section 15: Credentialing Contact Information

Application Completed by *(Name)**			
Credentialing Contact Name *(If different than above)*			
Mailing Address for Credentialing Correspondence Street*	City*	State*	Zip*
Email*	Phone	Fax	

SUBMIT FORM

If you are having difficulty submitting the form once completed, please send using one of the following methods:

- **Email:**
  - **Click on "File" at the top of your screen**
  - **Click on "Save As"**
  - **Save the completed form on your computer**
  - **Attach the completed form to an email and send to providerforms@bcbsnd.com**
- **Fax: 701-282-1910**
- **Mail: 4510 13th Ave. S.**
  Fargo, ND 58121