

# Practitioner Recredentialing Application



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**Instructions:** Recredentialing is conducted every 3 years. Once this application has been submitted, unless you hear otherwise, your continued participation obligations have been met. Read all instructions carefully prior to submitting your application.

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

Section 1: Personal Information <i>(Note: BCBSND may use this method for application follow-up)</i>			
Name (Do not use nicknames or initials, unless they are part of your legal name)			
Last Name	First Name	Middle Name	Suffix
Credential		National Provider Identification (NPI) Number	
Have you ever used another name? <input type="checkbox"/> Yes <input type="checkbox"/> 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
Email	Phone	Fax	

Section 2: Practice Location and Specialty Information		
<b>IMPORTANT:</b> Include a copy of your W-9 if your Tax ID or practice name has changed from what was submitted previously. If you have moved or changed employment, complete the Supplemental Additional Location form. Claims may be impacted if this information is not communicated.		
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)	Use: <input type="checkbox"/> Individual <input type="checkbox"/> Group
Billing NPI that is Submitted on Claims	Name of Practice	
Primary Practicing Specialty at this Location		
Board certified specialty? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Name of Certification Board		
Initial Certification Date (MM/DD/YYYY)	Recertification Date (MM/DD/YYYY)	Expiration Date (MM/DD/YYYY)
Group/Corporate Legal Name as it Appears on W-9		

Section 3: Professional IDs	
Include all state licenses, DEA Registrations and SAMHSA waivers.	
<b>IMPORTANT:</b> DEA registration should match the state in which you work. Provide all current and previous licenses/certifications.	
Federal DEA Number	<input type="checkbox"/> N/A
SAMHSA DEA Number	State of Registration
DEA Issue Date (MM/DD/YYYY)	DEA Expiration Date (MM/DD/YYYY)

**Section 3: Professional IDs (Continued)**

License Number	License Issuing State	
License Issue Date (MM/DD/YYYY)	License Expiration Date (MM/DD/YYYY)	
Are you currently practicing in this state? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>Other ID Numbers</b> (Note: Healthy Steps providers must be enrolled with Medicaid)		
Are you a participating Medicare provider? <input type="checkbox"/> Yes <input type="checkbox"/> No	Medicare Number	
Are you a participating Medicaid provider? <input type="checkbox"/> Yes <input type="checkbox"/> No	Medicaid Number	Medicaid State

**Section 4: 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	

**Section 5: 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. **Credentialing application cannot be processed without this attachment.**

**Section 6: Disclosure Questions Pertaining to Only the Past 3 Years**

Answer all questions. For any "Yes" response, provide an explanation on the supplemental Disclosure Question Explanation Form in Section 8. If question does not apply, answer "No."

1	Has your license or certification to practice in any jurisdiction been limited, restricted, revoked, suspended, voluntarily relinquished, terminated, subjected to disciplinary action or otherwise acted upon in an adverse manner?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2	Have you been sanctioned or penalized by any hospital, licensing board, government entity or managed care organization?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3	Have you voluntarily or involuntarily refused or denied membership on a hospital medical staff?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4	Have your specific clinical privileges at a facility in any jurisdiction ever been denied, limited, suspended, diminished, revoked, withdrawn or denied renewal?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5	Have you been subjected to disciplinary action by any medical organization?	<input type="checkbox"/> Yes <input type="checkbox"/> No
6	Have you been subjected to any claim(s) or under investigation for unethical conduct?	<input type="checkbox"/> Yes <input type="checkbox"/> No
7	Has your DEA license or narcotics registration ever been suspended or revoked?	<input type="checkbox"/> Yes <input type="checkbox"/> No

**Section 6: Disclosure Questions Pertaining to Only the Past 3 Years (Continued)**

Answer all questions. For any "Yes" response, provide an explanation on the supplemental Disclosure Question Explanation Form in Section 8. If question does not apply, answer "No."

8	Have you 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
9	Have any judgments been made against you or settlements by you in any malpractice claim?	<input type="checkbox"/> Yes <input type="checkbox"/> No
10	Have you been denied liability insurance, in whole or in part, or has your policy been canceled, involuntarily restricted, denied renewal, or rated up because of the nature of volume of claims against you?	<input type="checkbox"/> Yes <input type="checkbox"/> No
11	Has your employer changed in the past 3 years?	<input type="checkbox"/> Yes <input type="checkbox"/> No
12	Has your board status changed in the past 3 years? If yes, list specialty: 1st Specialty _____ 2nd Specialty _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
13	Have you been convicted of a felony, fraud, narcotics offense, moral, or any other type of ethical crime?	<input type="checkbox"/> Yes <input type="checkbox"/> No

**Section 7: Supplemental Form – Disclosure Question Details**

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

Empty box for supplemental information.

**Section 8: Patient Population Served**

**Please Identify The Age Range And Gender Of Patients Served (Check all that apply)**

<input type="checkbox"/> Preschool 0-5	<input type="checkbox"/> Adolescent 13-17	<input type="checkbox"/> Geriatrics 65+	<input type="checkbox"/> Female Patients
<input type="checkbox"/> Children 6-12	<input type="checkbox"/> Adults 18-65	<input type="checkbox"/> Male Patients	

Is provider currently accepting new patients?  Yes  No

## Section 9: Behavioral Health Providers Capability/Services

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.

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

## Section 10: Malpractice/Liability Insurance

Attach A Copy Of Malpractice/Liability Insurance Face Sheet.

Attach the malpractice insurance face sheet and evidence (e.g. roster, letter, fax) that clearly states the name of provider being credentialed and covered under your insurance policy. The face sheet must also contain the name of insurance company, from and through dates, policy number and occurrence/aggregate coverage amounts.

**Section 11: 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 consent to the use of an electronic signature and understand that by typing my name in the signature space or (print name\*) space in the Consent section of this application, I am affixing my electronic signature which has the same legal effect and enforceability as my handwritten signature. 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 complete, true and accurate to the best of my knowledge and belief.

Signature

Date (MM/DD/YYYY)

**Supplemental Additional Location Form on next page.**

**Please double check that the application is complete.**

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](mailto:providerforms@bcbsnd.com)
- Fax: 701-282-1910
- Mail: 4510 13th Ave. S.  
Fargo, ND 58121

# Supplemental Additional Location Form



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Supplemental form to Practitioner Recredentialing Application. This form is not to be used to replace any other documentation.

Provider Information	
Provider Name	NPI
Specialties	

Additional Location Information		
Business/Corporation Name		Organization NPI
Practicing Address Street	Billing/Mailing Address <i>(If different from practicing address)</i> Street	
City	State	Zip
Is this the Primary Practice Location for this Provider? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Should this provider display in the directory? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Accepting new patients? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Patient Appointment Phone #	Clinic Telephone #	Provider Phone # <i>(If different from clinic)</i>
Tax Identification Number (TIN)		Effective Date

Additional Location Information		
Business/Corporation Name		Organization NPI
Practicing Address Street	Billing/Mailing Address <i>(If different from practicing address)</i> Street	
City	State	Zip
Is this the Primary Practice Location for this Provider? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Should this provider display in the directory? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Accepting new patients? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Patient Appointment Phone #	Clinic Telephone #	Provider Phone # <i>(If different from clinic)</i>
Tax Identification Number (TIN)		Effective Date