BlueCross BlueShield of Oklahoma

SOLO PROVIDER RECORD/CONTRACTING PACKET

The **Solo Provider Record/Contracting Packet** should be completed by:

- A provider who will not be employing another professional provider
- A provider who will be using his/her social security number (SSN) for tax purposes
- A provider whose Federal Tax Identification Number (TIN) is legally in the provider's name
- A provider who is not incorporated

The attached packet contains all of the forms that are required in order to be considered for network participation with Blue Cross and Blue Shield of Oklahoma (BCBSOK). Please fully complete all applicable information in its entirety. Completed packets can be emailed to Network Management *(preferred method)* or by fax or mail. The email address, fax number, and mailing address are indicated below.

Please discard any older applications, as they are no longer valid.

Billing Information – Social Security Number and Federal Tax Identification Number must be completed in its entirety; the name that will appear on any reimbursement or Form 1099 will be that of the party to which payment is made. We will only make provider payments to the individual that rendered the service(s) and supplied a Tax Identification Number belonging to the named individual. To receive a Provider Record and/or join the BCBSOK network, please complete the Provider Record/Contracting form below and the W-9 Form.

IMPORTANT – Please Note: ***Your assigned BCBSOK internal Solo Provider Record does NOT mean that you are a participating provider. Until you are credentialed and contracted and have an effective date, your claims will be processed as out-of-network.***

We look forward to assisting you in the future.

Complete the forms and return to:
EMAIL: OKNetworkManagement@bcbsok.com
Fax: 1-918-549-2141
Phone: 1-800-722-3730 (Say "NETWORK" or press 2)

MAIL:
Blue Cross and Blue Shield of Oklahoma
Attn: Network Management Department
P.O. Box 3283
Tulsa, OK 74102-3283

Please complete all information within. This packet will be returned if incomplete.

Attach copies of:

- State Medical License
- W-9
- Behavioral Health Professional Areas of Expertise (if appropriate)
- Hospital Coverage Letter
- Federal DEA license and State Controlled Substance registration
- Medicare and/or Medicaid certification letters
- Malpractice Liability Insurance
- Call Coverage Form
- Supervising Physician Protocols and Duties Supplemental Questionnaire
- Prescribing Authority Supplemental Questionnaire
- Clinical Laboratory Improvement Amendments (CLIA) – if applicable
- Provider Disclosure of Ownership and Control Interest Form

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BlueCross BlueShield of Oklahoma

SOLO PROVIDER RECORD/CONTRACTING FORM

Applying for:	**Applying as:**	**Specialty Information:**
❑ Provider Record only ❑ Provider Record and Participation in the BCBSOK Network	❑ Primary Care Physician ❑ Specialist Physician ❑ *CRNA, CNP, PAC, CNS, CNM ❑ Other Healthcare Professional Providers	❑ Board Certified Agency: _____ *If NOT Board Certified please provide date of Graduation/Residence (circle one) Completed: ___/___/_____ Primary Specialty:_____ Secondary Specialty:_____ Tertiary Specialty: _____

Are you associated with:

❑ IPA (Independent Physician Association) Name:_____

❑ PHO (Physician Hospital Organization) Name:_____

❑ Designated Essential Community Provider – examples: RHC, FQHC, Tribal or Planned Parenthood

Name: _____

❑ Health System Name:_____ Employed? Yes ❑ or No ❑

Provider Name (First, Middle, Last, Title/Degree): _____

Date of Birth:_____ Gender: Male ❑ Female ❑

OK State License #:_____

CAQH Provider ID:_____ Date Practice Started:_____

AANA Certification # (CRNAs only):_____ Effective Date: _____

Supervising Physician(s) if applicable:_____

*WILL REQUIRE COMPLETED PROTOCOL & PRESCRIBING AUTHORITY

Billing Information:

Social Security Number:_____ Tax Identification Number (TIN): _____

Level 1 – Individual NPI: _____ Level 2 – Organizational NPI:_____

Taxonomy Code(s):_____

Physical Address (Please attach a separate sheet for any additional addresses):

Address: _____

City: _____ State: _____ Zip: _____ County: _____

Appointment Phone #: _____ Fax #: _____

Email Address: _____

Contact Name: _____ Phone # _____

Office Hours:

Mon _____ to_____ | Tue_____ to_____ | Wed _____ to_____ | Thu _____to_____ |

Fri _____ to_____ | Sat _____to_____ | Sun _____to_____ |

BlueCross BlueShield of Oklahoma

Billing/Payee Address (Mail Check To):

Address: _____

City: _____ State: _____ Zip: _____ County: _____

Phone #: _____ Fax #: _____

Email Address: _____

Contact Name: _____ Phone # _____

Credentialing/Correspondence Address:

Address: _____

City: _____ State: _____ Zip: _____ County: _____

Phone #: _____ Fax #: _____

Email Address: _____

Contact Name: _____ Phone # _____

PRACTICE INFORMATION

1. Are you currently a Medicare provider in Oklahoma? Yes ❑ No ❑ Medicare PTAN:_____

2. Are you currently a Medicaid provider in Oklahoma? Yes ❑ No ❑ Medicaid Number:_____

3. Does this facility have wheelchair access? Yes ❑ No ❑

4. Does the physical location provide screening mammography services? Yes ❑ No ❑
   Scheduling Phone Number:

5. Any limitations to practice (e.g., gyn only, only up to 18 years of age, females only, etc):

6. Any limitations to weekly practice hours (please list open days and hours of business):

7. Do you or your staff speak other languages? Yes ❑ No ❑
   If yes, which languages:

8. List admitting hospital privileges (if applicable):

9. Do you render laboratory services? Yes ❑ No ❑ If Yes, please provide your CLIA number and describe testing methodology performed. CLIA Number: _____
   Testing Methodology: _____

10. Do you render Telemedicine Services? Yes ❑ No ❑
    Are you physically located in Oklahoma at the time services are rendered? Yes ❑ No ❑. If No, please explain:
    _____
    _____
    _____

Continued on next page

BlueCross BlueShield of Oklahoma

PRACTICE INFORMATION (continued)

11. Where do you render services for this location? (i.e. office, hospital, surgery center, etc):_____

12. What place of Service (POS) code will you bill for this location? (i.e. office- POS 11, hospital- POS 21, surgery center- POS 24, etc): _____

13. Services performed at this location:

_____

14. Does your physical/mental health limit you in any way from performing your duties as a physician?	Yes ❑	No ❑
15. While practicing medicine, have you ever been impaired by alcohol or other chemical substances?	Yes ❑	No ❑
16. Have your privileges at any hospital ever been restricted, revoked, or not renewed?	Yes ❑	No ❑
17. Have you ever been listed on an OIG or other government sanction list?	Yes ❑	No ❑
18. Have you ever been Debarred by Medicare/Medicaid?	Yes ❑	No ❑
19. Have you ever been a BCBSOK Participating provider before?	Yes ❑	No ❑
20. Do you currently have malpractice insurance of at least $1million/$1million for physicians or $500,000/$1 Million for Heath Care Professionals?	Yes ❑	No ❑
21. Have you ever been denied professional liability insurance or has your coverage ever been canceled or terminated? If Yes, please explain.	Yes ❑	No ❑
22. Have there in the past five (5) years, or are there currently pending, any malpractice claims, settlements, judgments, or arbitration proceedings involving your professional practice?	Yes ❑	No ❑
23. Has your present professional liability insurance carrier excluded any specific procedures or imposed other restrictions on your coverage? If yes, please list the procedures which have been excluded with an explanation.	Yes ❑	No ❑
24. Are you able to perform the procedures and essential functions of the position for which you have applied, with or without reasonable accommodation, according to accepted standards of professional performance and without posing a direct threat to patients? If no, please explain on a separate sheet.	Yes ❑	No ❑

All "yes" answers below require full explanation on a separate sheet.

25. Have any of the following ever been, or are any currently in process or pending, either on a voluntary* or involuntary basis: denied, revoked, suspended, reduced, limited, canceled, sanctioned, placed on probation, not renewed or relinquished for disciplinary reasons?

***A voluntary relinquishment or voluntary non-renewal is for disciplinary reasons when the relinquishment or non-renewal is done to avoid an adverse action, preclude an investigation, or is done while the provider is under investigation related to professional conduct.**

a. Medical license in any state	Yes ❑	No ❑
b. Other professional registration or license	Yes ❑	No ❑
c. DEA registration	Yes ❑	No ❑
d. Oklahoma BNDD (or other state narcotics registration)	Yes ❑	No ❑
e. Academic appointment	Yes ❑	No ❑
f. Membership on any hospital or healthcare facility medical staff	Yes ❑	No ❑
g. Clinical privileges, prerogatives or rights on any medical staff	Yes ❑	No ❑

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BlueCross BlueShield of Oklahoma

PRACTICE INFORMATION (continued)

h. Membership in a healthcare organization or facility	Yes ❑ No ❑
i. Professional society membership or fellowship	Yes ❑ No ❑
j. Any other type of professional reprimand or sanction	Yes ❑ No ❑
k. Board certification	Yes ❑ No ❑
l. ECFMG certification	Yes ❑ No ❑
m. Participation in the Medicare or Medicaid program or other Government health benefits program, including debarment	Yes ❑ No ❑
26. Has your employment at a health care organization ever been terminated?	Yes ❑ No ❑
27. Have you ever been charged or convicted of a crime other than a minor traffic offense?	Yes ❑ No ❑
28. Have you ever been convicted of a felony or are there any felony charges pending against you?	Yes ❑ No ❑
29. Have you ever withdrawn your application for appointment, reappointment, and/or clinical privileges or resigned from the medical staff or surrendered your clinical privileges while under investigation or before a recommendation or decision by a hospital's or health care facility's medical executive or governing board was rendered?	Yes ❑ No ❑
30. Have you ever been subjected to actions by a utilization and quality control Peer Review Organization (PRO)?	Yes ❑ No ❑
31. Have you ever been terminated, rejected, limited or been excluded or refused membership in a managed care organization (HMO, PPO, PHO, etc.) for a stated reason?	Yes ❑ No ❑
32. Are you currently (or have you been in the past five (5) years) engaged in the illegal use of drugs or substance abuse?	Yes ❑ No ❑
33. Has there been a gap of six (6) months or greater in your academic or professional career for the previous five (5) years?	Yes ❑ No ❑

If you answered yes to any of the above questions, please include a detailed letter of explanation.

Comments or additional information you would like to provide:

To the best of my knowledge, the information supplied on this document is accurate and complete.

Upon submission of this application, provider hereby releases this information to Blue Cross and Blue Shield of Oklahoma for the purpose of establishing a BCBSOK Solo Provider Record.

Please complete all information above. This form will be returned if incomplete.

_____ Name of Signatory

_____ Title of Signatory

_____ Authorized Signature

_____ Date Signed

INTERNAL USE ONLY
PAR / PPO / EPPN / CAR / P65 / WCO / HMO / BAV PPO / MA PPO / MA HMO
PROVIDER ID: _____CONTRACT ID:_____

SIGNATURE TYPE: HAND / ELEC. / ROSTER
PRACTICING AS: PCP / SPECIALIST / ALEX

Continued on next page

BlueCross BlueShield of Oklahoma

CATEGORY DESCRIPTIONS	
TYPE	**DESCRIPTION**
Solo Physician	Physician is a Primary Care Physician or a Specialty Care Physician – MD's, DO's, DPM's
Solo Health Care Professional	Includes: Audiologist Chiropractor Optometrist Physical Therapist Registered Dietician Speech and Language Pathologist Occupational Therapist Behavioral Health Professionals Psychology Licensed Clinical Social Work Licensed Professional Counselor Licensed Alcohol and Drug Counselor Mid-Level Health Professionals Certified Nurse Practitioner Certified Registered Nurse Anesthetist Clinical Nurse Specialist Physician Assistant Other professional service providers – If your provider type and/or specialty is not listed above, please contact our Professional Network Management at 800-722-3730.

BlueCross BlueShield of Oklahoma

Provider Disclosure of Ownership and Control Interest Form

Name of Entity/Individual	TIN	NPI

1. Has the disclosing provider, or any "person who has ownership or control interest" in the disclosing provider, or any person who is an "agent" or "managing employee" of the disclosing provider, been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the Title XX services program since the inception of those programs? (Definitions may be found at 42 CFR Sections 101, et seq.). If yes, give the name(s) of person(s) and description(s) of offense(s). Please use additional pages if necessary:

Name	TIN	Date of Birth	Description

2. Definition: A managing employee is 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 operations of an institution, organization, or agency." (42 CFR section 455.101) Managing employees are in a position to exert influence over the conduct of the provider's operations and includes officers, governing boards, or board of directors.

Name	TIN	Address	Date of Birth

3. Provide the name and address of each person with an ownership or control interest in the disclosing provider or in any subcontractor in which the disclosing provider has direct or indirect ownership of five percent or more. For corporations that have an ownership or control interest in the disclosing entity, please separately list its primary business address, every business location and Post Office Box address. Please use additional pages if necessary:

Name	TIN	Address	Date of Birth

4. Is any person named in question #3 related to another as spouse, parent, child, or sibling? If yes, give the name(s) of person(s) and relationship(s). Please use additional pages if necessary. *NOTE: Designate relationship to each person listed in question #3 by using A., B., C., etc.*

Name	Relationship

Certification:

I certify that the above disclosed information is true and correct to the best of my knowledge as of the date set forth below.

Signature _____ **Date** _____

Title _____ **Position** _____

Printed name _____

BlueCross BlueShield of Oklahoma

Hospital Coverage Letter

To: Blue Cross and Blue Shield **Date:** _____

Please accept this correspondence as confirmation that since I do not have active admitting privileges at a BCBS participating network hospital, with the exception of medical emergencies, my practice will be confined to outpatient.

If non-emergency hospitalization is necessary, I will refer care to a BCBS participating network practitioner that has active admitting privileges at a participating network facility.

Practitioner's Name: _____
(please print name legibly)

Practitioner's Signature: _____

DESIGNATED PRACTITIONER(S):

Name of Designated Admitting Network Practitioner: ☐ **HMO** ☐ **PPO**

_____
(please print name legibly)

Name of Designated Admitting Network Practitioner: ☐ **HMO** ☐ **PPO**

_____
(please print name legibly)

If Designated Admitting Practitioner is a Hospitalist, please provide the name of the Hospitalist Group and their Group Tax Identification Number below:

Name of Hospitalist Group: _____
(please print name legibly)

Hospitalist Group TAX ID #: _____
(please print name legibly)

Note: *If you are unsure of the network status of a practitioner and/or a hospital, please contact your local Blue Cross and Blue Shield Network Management office.*

BlueCross BlueShield of Oklahoma

CALL COVERAGE DESIGNATION & CREDENTIALING CONTACT INFORMATION FORM

Requirements:

- Physician agrees to provide coverage for Members twenty-four (24) hours per day, seven (7) days per week by a network Participating Provider.
- The Call Coverage Physician and Applying Physician must participate in the same networks, but if the Call Coverage Physician is participating in additional networks that is fine.
- The Call Coverage Physician and the Applying Physician must be credentialed in the same specialty.
  - Exception – if the Applying Physician is in a rural setting where there is not another physician in the same specialty, a physician in a similar specialty may be approved.
- Call Coverage must be established prior to the credentialing approval of the Applying Physician.

Useful Tool:
It may be helpful to use our Provider Finder tool to assist in finding a Call Coverage Physician participating in the same networks and specialty. Go to *www.bcbsok.com* and click the link on the Home Page called "Find a Doctor". You can search providers in an area by specialty and view that provider's network participation.

Applying Physician's Name: _____
(please print name legibly)

Applying Physician's/ Authorized Signature: _____

DESIGNATED Call Coverage Physician(s): _____
(please print name(s) legibly)

Do the Call Coverage and Applying Physician Specialties Match (please circle)? Yes / No

If "no", why? _____

Is there a patient age restriction concern between the Applying and Call Coverage Physician?

If so, explain. _____

Admitting Privileges? Yes / No (Please circle.)

Hospital(s): _____

Credentialing Contact Information

Credentialing Contact Name: _____ Phone: _____

Credentialing Contact Email: _____

Credentialing Contact Address, City, State, Zip: _____

_____

Internal Use – Network Representative Completes Below:

Network Representative Name: _____ **Representative Contact Information:** _____