BlueCross BlueShield of Oklahoma

PROFESSIONAL PROVIDER RECORD/CONTRACTING PACKET

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Please discard any older applications, as they are no longer valid.

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 (if applicable – Please refer to Credentialing Requirement Check List and Requirements for your provider type found at *http://www.bcbsok.com/provider/network/credentialing.html*)
- Federal DEA license and State Controlled Substance registration
- Medicare and/or Medicaid certification letters
- Malpractice Liability Insurance
- Call Coverage Form
- Prescribing Authority Supplemental Questionnaire
- Clinical Laboratory Improvement Amendments (CLIA) – if applicable
- College of American Pathologists (CAP) – if applicable
- Provider Disclosure of Ownership and Control Interest Form

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BlueCross BlueShield of Oklahoma

PROFESSIONAL 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/Residency (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 #: _____

Contact Name: _____ Phone # _____

Office Hours:

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

Fri _____ to_____ | Sat _____to_____ | Sun _____to_____ |

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Billing/Payee Address (Mail Check To):

Address: _____

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

Phone #: _____ Fax #: _____

Contact Name: _____ Phone # _____

Credentialing/Correspondence Address:

Address: _____

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

Phone #: _____ Fax #: _____

Contact Name: _____ Phone # _____

Email Contact Information:

Communications Email:_____ Credentialing Email:_____

Contracting Email: _____

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. Does provider 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:
    _____
    _____
    _____

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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. What specific services do you perform 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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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

_____ Provider Signature

_____ Date Signed

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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 Licensed Psychologist 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.

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