BlueCross BlueShield of Oklahoma

SOLO PROVIDER ONBOARDING FORM

Complete the form and return to:

EMAIL: OKNetworkManagement@bcbsok.com
FAX: 918-549-2141
PHONE: 800-722-3730 (Option 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.

SUBMITTER INFORMATION

FIRST NAME	MIDDLE INITIAL	LAST NAME	SUFFIX
EMAIL ADDRESS		TELEPHONE NUMBER	
JOB TITLE/ POSITION			
NETWORK PARTICIPATION (SELECT ONE) ☐ PARTICIPATE IN-NETWORK ☐ PARTICIPATE OUT-OF-NETWORK		☐ COMPLETING THE FORM FOR CONTRACT AS SOLO PROVIDER	

PRACTITIONER INFORMATION

IS THE PROVIDER CURRENTLY IN A RESIDENCY PROGRAM? ☐ YES ☐ NO	
PRIMARY PROVIDER TYPE Licensed Marriage/Family Therapy (LMFT)	PRIMARY PROVIDER SPECIALTY
PRIMARY PROVIDER SUB-SPECIALTY	CAQH/ HSC NUMBER
LICENSE NUMBER	TAX IDENTIFICATION NUMBER (TIN)

PERSONAL INFORMATION

FIRST NAME	MIDDLE INITIAL	LAST NAME	SUFFIX
JOB TITLE/ POSITION		DATE OF BIRTH	GENDER

ADDITIONAL PERSONAL & PRACTITIONER INFORMATION

APPLYING AS (SELECT ONE): ☐ PRIMARY CARE PHYSICIAN/ PROVIDER ☐ SPECIALTY CARE PHYSICIAN/ PROVIDER	
PROVIDER TYPE	PROVIDER SPECIALTY
PROVIDER SUB-SPECIALTY	WILL YOU BE JOINING A MEDICARE NETWORK? ☐ YES ☐ NO
MEDICARE NUMBER	DEA NUMBER
HOSPITAL ADMITTING PRIVILEGES	ADMITTING HOSPITAL TYPE 2 NPI
AMBULATORY SURGERY CENTER PRIVILEGES	LANGUAGE(S) SPOKEN
CULTURAL COMPETENCY TRAINING COMPLETED? ☐ YES ☐ NO	COMPLETION DATE
TYPE 1 NPI (INDIVIDUAL)	SOCIAL SECURITY NUMBER
ETHNICITY	PRACTITIONER WEBSITE URL OR N/A

OFFICE PHYSICAL LOCATION

LOCATION NAME	OFFICE CONTACT NAME	
TELEPHONE NUMBER	FAX NUMBER	
ADDRESS LINE 1		
ADDRESS LINE 2		
CITY	STATE	ZIP CODE
EMAIL ADDRESS	APPOINTMENT PHONE NUMBER	START DATE AT THIS LOCATION
LOCATION OFFERS LANGUAGE LINE SERVICES ☐ YES ☐ NO	LANGUAGE/TRANSLATION SERVICES	

SERVICING PRACTICE LOCATIONS (CHECK ALL THAT APPLY) ☐ PATIENT'S HOME VISITS ONLY ☐ PATIENT'S WORK PLACE VISITS ONLY

☐ HOSPICE VISITS ONLY ☐ NURSING HOME VISITS ONLY ☐ SKILLED NURSING FACILITY VISITS ONLY

SERVICE(S) PERFORMED AT THIS LOCATION

SUPERVISING PHYSICIAN	SUPERVISING PHYSICIAN TYPE 1 NPI NUMBER
SUPERVISING PHYSICIAN SPECIALTY	
BACK UP PROVIDER	BACK UP PROVIDER NPI NUMBER

THIS IS PRIMARY LOCATION FOR THIS PROVIDER ☐ YES ☐ NO
PLEASE EXCLUDE FROM PROVIDER DIRECTORY ☐ YES ☐ NO
THIS LOCATION IS ACCEPTING NEW PATIENTS ☐ YES ☐ NO

HOURS OF OPERATION

TIME ZONE ☐ PACIFIC ☐ MOUNTAIN ☐ CENTRAL ☐ EASTERN

	MON	TUES	WED	THURS	FRI	SAT	SUN
OPENING TIME							
CLOSING TIME							

AMERICANS WITH DISABILITIES ACT (ADA)

ARE THE FOLLOWING STANDARDS IN ACCORDANCE WITH AMERICAN WITH DISABILITIES ACT?

CLOSE PROXIMITY TO PUBLIC TRANSPORTATION	☐ YES ☐ NO	EXAM ROOM	☐ YES ☐ NO
EXAM TABLE	☐ YES ☐ NO	EXTERIOR BUILDING	☐ YES ☐ NO
INTERIOR BUILDING	☐ YES ☐ NO	OFFICE RECEPTION AREA	☐ YES ☐ NO
PARKING ACCESSIBILITY	☐ YES ☐ NO	RESTROOM	☐ YES ☐ NO
SCALE	☐ YES ☐ NO	SITE ACCESSIBLE	☐ YES ☐ NO

TREATING CATEGORIES

DOES THE PROVIDER TREAT THE FOLLOWING? PLEASE CHECK AT LEAST ONE.			
BLINDNESS OR VISUALLY IMPAIRED	☐ YES ☐ NO	HOMEBOUND	☐ YES ☐ NO
CHRONIC ILLNESS	☐ YES ☐ NO	HOMELESS	☐ YES ☐ NO
CO-OCCURRING DISORDERS	☐ YES ☐ NO	PHYSICAL DISABILITIES	☐ YES ☐ NO
DEAFNESS OR HARD OF HEARING	☐ YES ☐ NO	SERIOUS MENTAL ILLNESS	☐ YES ☐ NO
HIV/AIDS	☐ YES ☐ NO		

ASSOCIATIONS

IPA (INDEPENDENT PHYSICIAN ASSOCIATION)	NAME
	SITE NUMBER
	TAX ID
PHO (PHYSICIAN HOSPITAL ORGANIZATION)	NAME
	SITE NUMBER
	TAX ID
HEALTH SYSTEM	NAME
	EMPLOYED BY HEALTH SYSTEM? ☐ YES ☐ NO
FEDERALLY QUALIFIED HEALTH CENTER (FQHC)	NAME
	SITE NUMBER
	TAX ID
COMMUNITY MENTAL HEALTH CENTER (CMHC)	NAME
	SITE NUMBER
	TAX ID
RURAL HEALTH CLINIC (RHC)	NAME
INDIAN HEALTH SERVICES FACILITY	NAME
PLANNED PARENTHOOD	NAME
CORE SERVICE AGENCY (CSA)	NAME

CORRESPONDENCE ADDRESS

SAME AS OFFICE PHYSICAL LOCATION ☐ YES ☐ NO		USE DIFFERENT ADDRESS ☐ YES ☐ NO
OFFICE CONTACT NAME		
TELEPHONE NUMBER		FAX NUMBER
ADDRESS LINE 1		
ADDRESS LINE 2		
CITY	STATE	ZIP CODE
EMAIL ADDRESS		

BILLING ADDRESS

SAME AS CORRESPONDENCE ADDRESS ☐ YES ☐ NO		USE DIFFERENT ADDRESS ☐ YES ☐ NO
OFFICE CONTACT NAME		
TELEPHONE NUMBER		FAX NUMBER
ADDRESS LINE 1		
ADDRESS LINE 2		
CITY	STATE	ZIP CODE
EMAIL ADDRESS		

CREDENTIALING ADDRESS

SAME AS BILLING ADDRESS ☐ YES ☐ NO		USE DIFFERENT ADDRESS ☐ YES ☐ NO
OFFICE CONTACT NAME		
TELEPHONE NUMBER		FAX NUMBER
ADDRESS LINE 1		
ADDRESS LINE 2		
CITY	STATE	ZIP CODE
EMAIL ADDRESS		

ADMINISTRATIVE CONTACT

NAME	JOB TITLE/ POSITION
TELEPHONE NUMBER	FAX NUMBER
EMAIL ADDRESS	
COMMENTS	

PRACTICE INFORMATION

TELEMEDICINE			
DO YOU RENDER TELEMEDICINE SERVICES?	☐ YES ☐ NO	SCHEDULING TELEPHONE NUMBER	☐ YES ☐ NO
LAB SERVICES			
DO YOU RENDER LABORATORY SERVICES?	☐ YES ☐ NO	CLIA NUMBER	
DESCRIBE TESTING METHODOLOGY			

LACTATION SERVICES

DO YOU PROVIDE LACTATION/BREASTFEEDING SUPPORT SERVICES, INCLUDING COUNSELING AND EDUCATION?	☐ YES ☐ NO

MEDICATION-ASSISTED TREATMENT (MAT)

THE FOLLOWING CRITERIA MUST BE MET FOR THE ANSWER TO BE YES:
- THE PROVIDER AT THIS LOCATION PROVIDES MAT FOR OPIOID USE DISORDERS.
- THE PROVIDER MUST BE ACTIVELY ACCEPTING AND ELIGIBLE TO TREAT NEW PATIENTS SEEKING MAT BASED ON THE LIMITS OF THEIR DRUG ADDICTION TREATMENT ACT OF 2000 (DATA 2000) WAIVER.

IS MEDICATION-ASSISTED TREATMENT (MAT) FOR OPIOID USE DISORDERS AVAILABLE AT THIS LOCATION?	☐ YES ☐ NO
IF YES, DO YOU WANT TO DISCLOSE THIS INFORMATION TO OUR MEMBERS BY BEING LISTED IN OUR ONLINE PROVIDER FINDER?	☐ YES ☐ NO
IS COUNSELING PROVIDED FOR OPIOID USE DISORDERS PROVIDED AT THIS SERVICE LOCATION?	☐ YES ☐ NO
IF YES, DO YOU WANT TO DISCLOSE THIS INFORMATION TO OUR MEMBERS BY BEING LISTED IN OUR ONLINE PROVIDER FINDER?	☐ YES ☐ NO

QUESTIONNAIRE

1. HAVE YOU EVER BEEN A BCBSOK PARTICIPATING PROVIDER BEFORE?	☐ YES ☐ NO
2. DO YOU CURRENTLY HAVE MALPRACTICE INSURANCE OF AT LEAST $1 MILLION FOR PHYSICIANS OR $500,000/$1 MILLION FOR HEALTH CARE PROFESSIONALS?	☐ YES ☐ NO
3. HAS YOUR 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
4. HAVE YOU EVER BEEN SUBJECTED TO ACTIONS BY A UTILIZATION AND QUALITY CONTROL PEER REVIEW ORGANIZATION (PRO)?	☐ YES ☐ NO
5. HAS THERE BEEN A GAP OR SIX (6) MONTHS OR GREATER IN YOUR ACADEMIC OR PROFESSIONAL CAREER FOR THE PREVIOUS FIVE (5) YEARS?	☐ YES ☐ NO
EXPLANATION	

ATTACHMENTS

PROVIDER NPI NUMBER	❑ YES ❑ NO	DISCLOSURE OF OWNERSHIP & CONTROL INTEREST FORM	❑ YES ❑ NO
PROVIDER LICENSE NUMBER	❑ YES ❑ NO	SUPERVISING PHYSICIAN NPI NUMBER	❑ YES ❑ NO
CAQH PROOF OF COMPLETION	❑ YES ❑ NO	BACKUP PROVIDER NPI	❑ YES ❑ NO
PROOF OF MEDICAID NUMBER	❑ YES ❑ NO	W-9	❑ YES ❑ NO
HOSPITAL COVERAGE LETTER	❑ YES ❑ NO	CULTURAL COMPETENCY CERTIFICATE	❑ YES ❑ NO
IRS 147C	❑ YES ❑ NO	OTHER	❑ YES ❑ NO
COMMENTS			

ATTESTATION

AUTHORIZED NAME	
TITLE	
TAX IDENTIFICATION NUMBER	TODAY'S DATE

CONTACT US

For status or if you have questions regarding your submission please email: **oknetworkmanagement@bcbsok.com**