

Texas Standardized Credentialing Application Completion Guide

To ensure your Texas Standardized Application is submitted complete, please utilize the guidelines below:

Page	Section	Requirements
	Behavioral Health Form	If you are a Behavioral Health Professional, this form must be completed and returned along with the credentialing application. Note: TRICARE Behavioral Professionals will need to complete the form below.
	Behavioral Health Form/TRICARE	If you are a TRICARE Behavioral Health Professional, this form must be completed and returned with the credentialing application.
	Hospital Referral Form	Please complete this form if you do not have admitting privileges at a network hospital and returned along with other applicable documents.
1-20	Texas Standardized Credentialing Application	<ul style="list-style-type: none"> • Please complete pages 1-20, and • Attachments; if applicable
1	Individual Information	<ul style="list-style-type: none"> • Type of Professional • Name (Last, First) • Social Security Number • Female or Male box must be checked. • Date of Birth (mm/dd/yyyy)
1-2	Education	<ul style="list-style-type: none"> • Professional Degree (Medical, Dental, Chiropractic, etc.) • Issuing Institution • City, State/Country • Degree • Attendance Dates (mm/yyyy to mm/yyyy)
2	Professional/Specialty Information	<ul style="list-style-type: none"> • Primary Specialty • Do you wish to be listed in the directory? • Secondary specialty • Do you wish to be listed in the directory?
3	Work History	<ul style="list-style-type: none"> • Current Practice/Employer Name • Start Date/End Date (mm/yyyy to mm/yyyy) • Previous Practice/Employer Name (chronological listing) • Start Date/End Date (mm/yyyy to mm/yyyy) • Gap Dates (mm/yyyy to mm/yyyy) and Explanation for any gaps greater than 6 months.
4	Hospital Affiliation	<ul style="list-style-type: none"> • Hospital • City • State • Hospital Referral letter is need if you do not have any admitting privileges at a network facility.
5	Professional Liability Insurance Coverage Call Coverage	<ul style="list-style-type: none"> • Complete the liability insurance coverage section • Call Coverage for PCPs

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6	Practice Location Information	<ul style="list-style-type: none"> Practice Location Address City State Phone Number Hours Patients Are Seen Are you currently practicing at this location, if answered NO please provide a start date. TIN
8	SECTION II Disclosure Questions	<p>All questions must be answered YES or NO</p> <ul style="list-style-type: none"> If any answers are Yes, page 10 must be attached with the application or explanatory documentation must be attached with the application.
9	SECTION II Disclosure Questions	<p>All questions must be answered</p> <ul style="list-style-type: none"> If any answers are Yes other than 16, page 10 must be attached with the application. If #16 is answered Yes, Attachment G or explanatory documentation must be attached with the application.
10	SECTION II Disclosure Questions	<ul style="list-style-type: none"> Explanation form or explanatory documentation required for all Yes answers except for question 16.
11	SECTION III Standard Authorization, Attestation and Release	<p>BCBSTX name must be entered as the entity</p> <ul style="list-style-type: none"> Applicant's Initials Date applicant initialed page 11 (mm/dd/yyyy) <p>Note: Two digit year is acceptable.</p>
12	SECTION III Standard Authorization, Attestation and Release	<ul style="list-style-type: none"> Applicant's Signature Applicant's name printed or typed Date applicant signed page 12 (mm/dd/yyyy) <p>Note: Two digit year is acceptable.</p>
20	Attachment G - Malpractice Claim History	Explanation if Question #16 on page 9 was answered YES; as applicable

Additional Requirements by Provider Type:

Provider Type	Additional Items Required
All providers	<ul style="list-style-type: none"> Copy of a current malpractice carrier declaration (face sheet) with coverage dates and limits or current malpractice
APNs	<ul style="list-style-type: none"> Copy of protocols or other written authorization signed by the APN and a BCBSTX participating physician
RNFA/PA	<ul style="list-style-type: none"> Supervision form found on the Texas Medical Board website

***NOTE:** To ensure compliance with TDI guidelines and compliance with internal standards, BCBSTX will not accept the following:

- Stamped provider signature;
- White out on required information, no exceptions;
- Scratch outs without the provider's initials;
- Disclosure questions unanswered or answered N/A;
- BCBSTX is not entered as the entity on Page 11.