

**Blue Cross Blue Shield of Texas (BCBSTX)
Texas Standardized Credentialing Application (TSCA)
Cover Page**

Please return both the Cover Page and the completed application.

**Applying for participation in one of the following networks with
Blue Cross and Blue Shield of Texas, a Division of Health Care Service Corporation, a Mutual Legal Reserve
Company, an Independent Licensee of the Blue Cross and Blue Shield Association**

- BlueChoice®** **HMO Blue® Texas** **TriCare (El Paso Only)** **Blue Medicare PPO**

Provisional Status for Physicians (MD/DO) contracted with a Medical Group: Please indicate in the check box below if you wish to be considered for Provisional Status. Provisional Status means that you will be compensated for services provided to enrollees of the managed care plan(s) indicated above ("Health Plans") in the amounts and subject to the terms contained in the Medical Group's participation contract(s) with Blue Cross and Blue Shield of Texas ("Medical Group Agreement") as if you were a Medical Group Provider, as defined in the Medical Group Agreement, while your credentialing application is being processed.

Request Provisional Status

NOTE: If you indicate here that you are requesting Provisional Status, for your request to be processed, you and your Medical Group must sign the Provisional Status Addendum attached to this Cover Page and comply with the requirements identified there and in our guidelines at http://www.bcbstx.com/provider/provisional_status.htm.

Please list your NPI #: _____

MDs/DOs: If you employ Physician Assistants, Advanced Practice Nurses, or Registered Nurse First Assistants, do you have written policies, which are implemented and enforced and describe the duties of all such providers in accordance with the statutory requirements for licensure and supervision as appropriate? N/A _____ Yes _____ No _____

Advanced Practice Nurses and Certified Nurse Midwives: (1) Please attach written protocols or other written authorization with a Blue Cross and Blue Shield of Texas or HMO Blue Texas physician. (2) Please provide the name of the Blue Cross and Blue Shield of Texas or HMO Blue Texas physician with whom you have written protocols or other written authorization.

Physician's Name: _____ NPI #: _____

Physician Assistants: (1) Please attach a letter from your supervising Blue Cross and Blue Shield of Texas or HMO Blue Texas physician requesting your participation in the network. (2) Please provide the name of the Blue Cross and Blue Shield of Texas or HMO Blue Texas supervising physician.

Supervising Physician's Name: _____ NPI #: _____

Use of Ambulatory Surgery Centers (ASCs):

Do you utilize Ambulatory Surgery Centers? Yes _____ No _____

If yes, please provide the name(s) of the ASC(s) you utilize:

Please indicate if you want to receive credentialing/recredentialing correspondence* by e-mail and/or fax:

- Yes, I want to receive credentialing/recredentialing correspondence by e-mail and/or fax
 No, I do not want to receive credentialing/recredentialing correspondence by e-mail and/or fax

*If you elect to receive credentialing/recredentialing correspondence by e-mail and/or fax, the data you supply on page 6 of the Texas Department of Insurance Texas Standardized Credentialing Application will be used. *Non-response will default to yes.*