



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.*

Blue Cross and Blue Shield of Texas

PROVISIONAL STATUS ADDENDUM

This is in support of my request to be given Provisional Status as defined in the Cover Page, as provided for in the Texas Insurance Code, Subchapter C, Expedited Payment Process for Certain Physicians (“Provisional Status Law”). I hereby warrant, represent and agree as follows:

1. The Medical Group meets the requirements of the Provisional Status Law, Section 1452.101(5), and endorses my request and agrees to the terms hereof by executing this Addendum in the space provided below.
2. I am licensed in the State of Texas by, and am in good standing with, the Texas Medical Board, with no history of disciplinary action.
3. If Provisional Status is granted I agree to comply with the terms of the Medical Group Agreement as if I were a Medical Group Provider, including, without limiting the foregoing, its provisions requiring Medical Group Providers and Medical Group to hold enrollees of Health Plans harmless and prohibiting billing such enrollees, subject to the terms and conditions of the Medical Group Agreement. In addition, if Provisional Status is granted I agree to comply with the provisions of the Provisional Status Law, including, without limiting the foregoing, those requiring that enrollees of Health Plans be held harmless and prohibiting the billing of such enrollees by me or the Medical Group for any amounts that may become payable by me to BCBSTX in the event that BCBSTX determines that I fail to meet its credentialing standards and my Provisional Status is terminated, or otherwise, both during and after any termination of my Provisional Status, subject to the terms and conditions of the Provisional Status Law.
4. I acknowledge and fully understand that the granting to me of Provisional Status: (a) is not the result of any credentialing of me by BCBSTX and that BCBSTX will review and make a determination on my credentialing based on my application and other information in accordance with its standard credentialing processes and procedures; and (b) does not constitute an acceptance by BCBSTX of me as a Medical Group Provider as defined in the Medical Group Agreement or qualify me in any way as a participating provider in a BCBSTX network of providers.

I understand that you will notify me in writing of your decision whether to grant me Provisional Status and of the termination thereof, and that the terms and conditions of the Provisional Status, if granted to me, are set forth at http://www.bcbstx.com/provider/provisional_status.htm.

Agreed to: PHYSICIAN APPLICANT <hr style="width: 80%; margin-left: 0;"/> Physician Applicant Signature	Endorsed and agreed to: MEDICAL GROUP <hr style="width: 80%; margin-left: 0;"/> Authorized Signature
Print Name: _____ NPI #: _____ Date: _____	Print Name: _____ Title: _____ Date: _____