BlueCross BlueShield of Texas

CREDENTIALING/RECREDENTIALING ANCILLARY/HOSPITAL PROVIDER QUESTIONNAIRE

FPS CREDENTIALING:

Provider Type: _____ **BCBS Internal Record No.**_____

Name:_____ Physical Address:_____

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

Telephone Number: _____ Fax:_____

Primary Contact at Center:_____ E-Mail:_____

Telephone Number: _____ Fax:_____

Contractor Name: _____ E-Mail: _____
(Name/Title)

Address (include city and state): _____
(Where should notice of contractual changes be sent?)

Ancillary <u>Credentialing</u> Notification Contact Name / Title _____

Address: City: _____ State: _____ Zip: _____
(Where should recredentialing notices be sent?)

Payment Address: _____ City/State/Zip:_____

Federal Tax I.D. No.: _____ **NPI**: _____
(Copy of W9 is required for all new applications) (Copy of NPI Enumerator letter or email required)

TPIN# (Medicaid- Star/CHIP):_____ **Medicare Provider No.**:_____

<u>Accredited by (list all accreditations and certification that apply)</u>
Accreditation/Certification: ….. Yes □ No □ CMS Certification: …… Yes □ No □

Accrediting Body:_____ Last CMS Site Survey Date**:** _____

Expiration Date:_____ Expiration Date:_____
(Month, Day, Year) (Month, Day, Year)

Has your facility license or certification ever been revoked, reduced, denied, or suspended by others or voluntarily surrendered by the facility, or are any actions now under way, which could possibly lead to such conclusions?..... ….. Yes □ No □

If yes, please explain: _____

Is any regulatory agency in the process of investigating your facility? ..... …. Yes □ No □
If yes, state the reason? _____

<u>Insurance Information</u>:
Liability Insurance? ..... …. Yes □ No □
If yes, please attach evidence of liability insurance, including effective date and monetary limits.

Carrier: _____ Expiration Date: _____
(Month, Day, Year)

Coverage amount: Each Occurrence:_____ Aggregate: _____

Has your malpractice insurance ever been cancelled, non-renewed, restricted, or special rated?
……Yes □ No □
If yes, please explain: _____

_____

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General Profile Information :

Does this facility lease/ timeshare their equipment or Operating Room? Yes □ No□
If Yes, please list your current lease / timeshare client. (If additional space needed, please attach a listing.)

1. _____
2. _____

What physician or physician group does your facility use for the following services?

1. Radiology: Name _____ TIN# _____ Phone# _____
2. Anesthesiology : Name _____ TIN# _____ Phone# _____
3. Pathology/Laboratory: Name _____ TIN# _____ Phone # _____
4. Emergency Room Physicians: Name _____ TIN# _____ Phone# _____

Is this a Minority Business Enterprise:……..Yes □ No □
Is this a Women's Business Enterprise: …….. Yes □ No □
Is this a Disadvantaged Business Enterprise:……..Yes □ No □

Is your business a solely owned proprietorship? ……. Yes □ No □
If not, please describe your ownership/investment structure. Please indicate which party has majority ownership, majority financial responsibility and liability for the facility. Define vested interest percentage for each party:
(If additional space is needed, please attach a listing.)

Majority Owner Name:	**Percentage of interest:** %

Additional Investors:	**%**	**Additional Investors:**	**%**

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The following pages are by specialty.

Select the specialty below to go directly to that Specialties page.

BlueCross BlueShield of Texas

CREDENTIALING/RECREDENTIALING ANCILLARY/HOSPITAL PROVIDER QUESTIONNAIRE

IF AMBULANCE PROVIDER, PLEASE PROVIDE THE FOLLOWING INFORMATION:

Service Area (Counties or States) _____

Where are your bases located (City / State)? _____
Total number of transports in most recent fiscal year? _____Total number of bases?_____

What types of medical transports does your company provide?
Ground **(G)** ..... Yes □ No □
Fixed-Wing Air (**F**) ..... Yes □ No □
Rotary Wing Air (**R**) ..... Yes □ No □

Condition Scenario	Basic Life Support (BLS)	Advance Life Support (ALS)	Critical Care	Specialty Care
Burns				
Dialysis/Renal Failure				
High Risk OB				
Infection Control				
Intra-aortic Balloon Pump				
Neonatal				
Pediatric (PICU)				
Trauma				
Transplants				
Tracheotomy				
Ventilator				
Ventricular Assist Device (VAD)				

Proceed to Signature page

BlueCross BlueShield of Texas

CREDENTIALING/RECREDENTIALING ANCILLARY/HOSPITAL PROVIDER QUESTIONNAIRE

IF FREESTANDING IMAGING/RADIATION THERAPY CENTER PROVIDER, PLEASE PROVIDE THE FOLLOWING INFORMATION:

Does your Radiologist perform Interventional Procedures at this location? ……..Yes □ No □
This facility bills global _____ technical only_____ component.

Which Modalities do you currently offer? Please mark with an "X".

PET Scan		CT Scan		X-ray		Myleogram	
MRI–Open		Ultrasound		Bone Density		Nuclear Medicine	
MRI-Closed		Carotid Us		Mammography		Digital Mammography	
IVP		OB Ultrasound		Non-Invasive Vascular		Cardiac Nuclear Medicine	
MRA		MRM		Invasive Vascular		GI Studies	
IMRT		Brachytherapy		Accelerator		Simulator	

IF RADIATION THERAPY CENTER PROVIDER, PLEASE RESPOND:

Is the patient imaged daily before treatment begins? ……Yes □ No □
Do you have a Physicist on staff? ……Yes □ No □
Do you hold multi-disciplinary conferences with referring or other treating physicians?...Yes □ No □
Do you follow-up with the patient after they finish a course of treatment? ……Yes□ No □
If yes, how many months before follow-up contact is made? _____

Proceed to Signature page

BlueCross BlueShield of Texas

CREDENTIALING/RECREDENTIALING ANCILLARY/HOSPITAL PROVIDER QUESTIONNAIRE

IF FREESTANDING INDEPENDENT LABORATORY, PLEASE PROVIDE THE FOLLOWING INFORMATION:

Which services do you currently offer? Please mark with an "X".

Clinical Laboratory		Clinical Pathology	
Toxicology		Histopathology	
Genetics		Anatomical Pathology	
Molecular Pathology		Cytopathology	

IF DURABLE MEDICAL EQUIPMENT SUPPLIER, PLEASE PROVIDE THE FOLLOWING INFORMATION:

Do you provide medical equipment intended for use in the diagnosis of disease or other conditions, or in the cure, mitigation, treatment, or prevention of disease, in man or other animals?…….Yes □ No □
Do you provide medical oxygen cylinders to home health care agencies, welding supplies, or home bound patients?.....Yes □ No □
Do you supply hearing aid instruments? ……..Yes □ No □
Do you distribute drugs to anyone other than a consumer or patient? ……..Yes □ No □
Do you manufacture, prepare, propagate, compound, process package, repackage, or change the container, wrapper, or labeling of any drug product?..... ……. Yes □ No □
Are you categorized as a Pharmacy?.....Yes □ No □
Do you supply CPAP, IPPB, Nebulizers, RADs, Oxygen related services and devices, Ventilator or Respirator services?…… Yes □ No □

IF INFUSION THERAPY PROVIDER, PLEASE PROVIDE THE FOLLOWING INFORMATION:

Are you licensed to provide Home Health Services?.....Yes □ No□
(Do not respond if you subcontract services.)

Proceed to Signature page

IF MENTAL HEALTH SERVICES PROVIDER, PLEASE PROVIDE THE FOLLOWING INFORMATION:

1. Is the Supervising Physician a Board Certified Psychiatrist? ..... ……Yes □ No □
2. Is the Supervising Physician a certified Addictionologist? ..... ……Yes □ No □
3. Intake Phone #: _____

Which services do you currently offer? Please mark with an "X".

Services Provided			
Level of Care	**Age**	**Service**	**"X"**
Inpatient	Child	Mental Health	
		Substance Abuse	
		Detox.	
		Eating Disorder	
	Adolescent	Mental Health	
		Substance Abuse	
		Detox.	
		Eating Disorder	
	Adult	Mental Health	
		Substance Abuse	
		Detox.	
		Eating Disorder	
	Geriatric	Mental Health	
		Substance Abuse	
		Eating Disorder	
Residential	Child	Mental Health	
		Substance Abuse	
		Eating Disorder	
	Adolescent	Mental Health	
		Substance Abuse	
		Eating Disorder	
	Adult	Mental Health	
		Substance Abuse	
		Eating Disorder	
	Geriatric	Mental Health	
		Substance Abuse	
		Eating Disorder	

Proceed to next page

IF MENTAL HEALTH SERVICES PROVIDER, PLEASE PROVIDE THE FOLLOWING INFORMATION (cont.):

Which services do you currently offer? Please mark with an "X".

Services Provided			
Level of Care	**Age**	**Service**	**"X"**
Partial Hospitalization	Child	Mental Health	
		Substance Abuse	
		Eating Disorder	
	Adolescent	Mental Health	
		Substance Abuse	
		Eating Disorder	
	Adult	Mental Health	
		Substance Abuse	
		Eating Disorder	
	Geriatric	Mental Health	
		Substance Abuse	
		Eating Disorder	
Intensive Outpatient (IOP)	Child	Mental Health	
		Substance Abuse	
		Eating Disorder	
	Adolescent	Mental Health	
		Substance Abuse	
		Eating Disorder	
	Adult	Mental Health	
		Substance Abuse	
		Eating Disorder	
	Geriatric	Mental Health	
		Substance Abuse	
		Eating Disorder	
Outpatient	Child	Mental Health	
		Substance Abuse	
		Eating Disorder	
	Adolescent	Mental Health	
		Substance Abuse	
		Eating Disorder	
	Adult	Mental Health	
		Substance Abuse	
		Eating Disorder	

Proceed to next page

IF MENTAL HEALTH SERVICES PROVIDER, PLEASE PROVIDE THE FOLLOWING INFORMATION (cont.):

Which services do you currently offer? Please mark with an "X".

Services Provided			
Level of Care	**Age**	**Service**	**"X"**
Outpatient (cont.)	Child	Mental Health	
		Substance Abuse	
		Eating Disorder	
	Adolescent	Mental Health	
		Substance Abuse	
		Eating Disorder	
	Adult	Mental Health	
		Substance Abuse	
		Eating Disorder	
	Geriatric	Mental Health	
		Substance Abuse	
		Eating Disorder	
ECT	Inpatient	Adult	
		Geriatric	
	Outpatient	Adult	
		Geriatric	

Which of the following services do you currently offer?

Public Transportation Access	Yes ☐	No ☐
TDD Capacity	Yes ☐	No ☐
Wheelchair Accessibility	Yes ☐	No ☐

Proceed to next page

BlueCross BlueShield of Texas

IF HOSPITAL PROVIDER, PLEASE PROVIDE THE FOLLOWING INFORMATION:

Do you own freestanding imaging centers?.....Yes ☐ No ☐ Quantity:___
Do you own freestanding ambulatory surgery centers?.....Yes ☐ No ☐ Quantity:___
Do you own freestanding emergency room centers?..... Yes ☐ No ☐ Quantity: ___

SERVICE DESCRIPTION	SERVICE PROVIDED (YES or NO)?	LEVEL OF CARE (i.e., Trauma Level 1,2 ,3, or 4)	Number of Beds or Operating Rooms	License or Certification
Medical				
Surgical				
Intensive Care (ICU)				
Intermediate ICU				
Cardiac Care Unit (CCU)				
Obstetrics (OB)				
Neonatal (NICU)				
Orthopedics				
Trauma				
Psychiatric				
Detoxification				
Burn Care				
Oncology				
Rehabilitation (Inpatient)				
Hospice (Inpatient)				
Skilled Nursing				
Obesity (Bariatric Surgery)				
Gastrointestinal (GI)				
Emergency Room				

Please list any other services provided:

Proceed to Signature page

BlueCross BlueShield of Texas

The aforementioned information is true and correct to the best of my knowledge. (**Note**: signature is valid for 180 days.)

Name and title of person completing this form: _____

Signature: _____

Telephone Number: (____) _____ Date: _____

Completion of this form in no way guarantees BCBSTX acceptance into any BCBSTX Managed Care, Medicaid, Medicare Advantage or VA networks. Provider will be notified by letter when credentialing is approved. In order to participate in or maintain your participation in one of these network(s),

All supporting documents must be current and and be submitted with this application to the applicable email address for the provider's specialty as shown below:

Refer to the **Credentialing and Contracting Process for Ancillary Providers** section of the **How to Join** page on the provider website and use the **Ancillary Specialty Checklists** to assist with gathering supporting documents.

Submit the following specialties to: AncillaryContracting_N@BCBSTX.com

Ambulance
Disease Management
Free Standing Imaging
Long Term Acute Care
Radiation Therapy
Rehab Facilities - Inpatient Only

Submit the following specialties to: AncillaryContracting_SW@BCBSTX.com

Diabetes Management
Durable Medical Equipment
Hearing Aid Supplier
Home Health
Home Health Dialysis
Home Infusion Therapy
Hospice
Orthotics and Prosthetics
Post-Acute Brain Injury Facilities
Renal Dialysis
Skilled Nursing Facilities
Sleep Study Lab

Submit the following specialties to: AncillaryContracting_SE@BCBSTX.com

Ambulatory Surgery Centers
Cardiac Cath
Free Standing ER