



CREDENTIALING/RE-CREDENTIALING 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 Credentialing 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.: _____

Accredited by (list all accreditations and certification that apply)

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Has your facility license or certification ever been revoked, reduced, denied, or suspended by others or voluntarily surrendered by the facility, or are any actions now under way, which could possibly lead to such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? _____

Insurance Information:

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: _____



CREDENTIALING/RE-CREDENTIALING ANCILLARY/HOSPITAL PROVIDER QUESTIONNAIRE

General Profile Information :

Does this facility lease/ timeshare their equipment or Operating Room? Yes <input type="checkbox"/> No <input type="checkbox"/> If Yes, please list your current lease / timeshare client. (If additional space needed, please attach a listing.) <div style="text-align: center;"> 1. _____ 2. _____ </div>
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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# _____
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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.

[Ambulance](#)

[Free Standing Imaging/Radiation Therapy Center](#)

[Free Standing Independent Lab](#)

[Durable Medical Equipment](#)

[Infusion Therapy](#)

[Mental Health Provider](#)

[Hospital Provider](#)



CREDENTIALING/RE-CREDENTIALING 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)				

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CREDENTIALING/RE-CREDENTIALING ANCILLARY/HOSPITAL PROVIDER QUESTIONNAIRE

[Redacted box]

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".

Table with 7 columns and 6 rows listing medical modalities: PET Scan, MRI-Open, MRI-Closed, IVP, MRA, IMRT, CT Scan, Ultrasound, Carotid Us, OB Ultrasound, MRM, Brachytherapy, X-ray, Bone Density, Mammography, Non-Invasive Vascular, Invasive Vascular, Accelerator, Myleogram, Nuclear Medicine, Digital Mammography, Cardiac Nuclear Medicine, GI Studies, Simulator.

[Redacted box]

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? _____

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CREDENTIALING/RE-CREDENTIALING 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.)

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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.	
	Adolescent	Mental Health	
		Substance Abuse	
		Detox.	
	Adult	Mental Health	
		Substance Abuse	
		Detox.	
	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	

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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	

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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

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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:

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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