

# Practitioner Credentialing Application



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**Instructions:** Read all instructions carefully prior to submitting your application.

**Tips to avoid delays:** Complete only this application. Do not use another insurance plan's application. If handwritten, use a blue or black ink ball-point pen only. Do not use pencil. Print legibly. Complete all sections that are applicable to you. Include all additional information requested. Fields that include an asterisk indicate that a response is required. All other fields will be considered not applicable if left blank.

If you have any questions, please call 800-756-2749 or send an email to prov.net@bcbsnd.com.

Section 1: Personal Information <i>(Note: BCBSND may use this method for application follow-up)</i>			
Name (Do not use nicknames or initials, unless they are part of your legal name)			
Last Name*	First Name*	Middle Name	Suffix
Credential*			
Have you ever used another name? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, please list all other names used and their dates of use		Dates other name was used	
Other Last Name	Other First Name	Date Started	End Date
Gender* <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth (MM/DD/YYYY)*	SSN (XXX-XX-XXXX)*	
General Information			
Only enter a Foreign National Identification Number if you do not have an SSN. <i>(Note: BCBSND may use email, phone, or fax for application follow-up)</i>			
National Provider Identification (NPI) Number		Primary Specialty/Taxonomy	
Languages Spoken			
Home Address			
Street	City	State	9-Digit Zip
Email*	Phone*	Fax*	
Section 2: Professional IDs			
Include all state licenses, DEA Registrations and SAMHSA waivers. NOT APPLICABLE = N/A			
<b>IMPORTANT:</b> DEA registration should match the state in which you work. Provide all current and previous licenses/certifications.			
Federal DEA Number*			
SAMHSA DEA Number*		State of Registration	
DEA Issue Date (MM/DD/YYYY)		DEA Expiration Date (MM/DD/YYYY)	
License Number*		License Issuing State*	
License Issue Date (MM/DD/YYYY)*		License Expiration Date (MM/DD/YYYY)*	
Are you currently practicing in this state?* <input type="checkbox"/> Yes <input type="checkbox"/> No			
License Number		License Issuing State	

**Section 2: Professional IDs (Continued)**

License Issue Date (MM/DD/YYYY)	License Expiration Date (MM/DD/YYYY)	
Are you currently practicing in this state? <input type="checkbox"/> Yes <input type="checkbox"/> No		
License Number	License Issuing State	
License Issue Date (MM/DD/YYYY)	License Expiration Date (MM/DD/YYYY)	
Are you currently practicing in this state? <input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>Other ID Numbers</b> (Note: Healthy Steps providers must be enrolled with Medicaid)		
Are you a participating Medicare provider? <input type="checkbox"/> Yes <input type="checkbox"/> No	Medicare Number	
Are you a participating Medicaid provider?* <input type="checkbox"/> Yes <input type="checkbox"/> No	Medicaid Number	Medicaid State
ECFMG Number (Non-U.S./Canadian Graduate Only)	ECFMG Certificate Issue Date (MM/DD/YYYY)	
Non-U.S. or Canadian School Name	Degree Awarded	
Non-U.S. or Canadian School Address	Date of Completion (MM/DD/YYYY)	
City	State	Country Code

**Section 3: Education and Training**

Provide the appropriate information for the school that issued your highest degree achieved. School and graduation date required for MD or DO degree. Fifth Pathway Graduates, please complete the following sections: U.S. school that issued your certificate, the non-U.S. school where you attended, and the Fifth Pathway Institution where you completed your training.

Name of U.S. or Canadian School	Degree Issued	
Start Date (MM/DD/YYYY)	Graduation Date (MM/DD/YYYY)	
Street Address		
City	State	Zip
<input type="checkbox"/> U.S. or Canadian Graduate <input type="checkbox"/> Non-U.S./Canadian Graduate (See Other ID Section Above) <input type="checkbox"/> Fifth Pathway Graduate (See Other Id Section Above)	Fifth Pathway Institution (If applicable)	
<b>Training</b>		
List post-graduate training programs you attended. Use one section per institution. Please explain in Section 5, any post-graduate training gaps of three months or greater. Residency institution and completion date required for MD or DO degree.		
Institution/Hospital Name		
Street Address		
City	State	Zip
Phone	Fax	

### Section 3: Education and Training *(Continued)*

<input type="checkbox"/> Fellowship <input type="checkbox"/> Internship <input type="checkbox"/> Residency	Start Date (MM/DD/YYYY)	Completion Date (MM/DD/YYYY)
Institution/Hospital Name		
Street Address		
City	State	Zip
Phone	Fax	
<input type="checkbox"/> Fellowship <input type="checkbox"/> Internship <input type="checkbox"/> Residency	Start Date (MM/DD/YYYY)	Completion Date (MM/DD/YYYY)
Institution/Hospital Name		
Street Address		
City	State	Zip
Phone	Fax	
<input type="checkbox"/> Fellowship <input type="checkbox"/> Internship <input type="checkbox"/> Residency	Start Date (MM/DD/YYYY)	Completion Date (MM/DD/YYYY)

### Section 4: Work History

Include a chronological work history for the past 5 years. Current position appears in Section 6. If graduation date was less than 5 years ago, any work history from that date forward is sufficient. **If there are any gaps in your work history, please explain at the bottom of this section.**

Practice Employer Name			
Street Address			
City	State	Zip	
Phone	Fax	Start Date	End Date
Practice Employer Name			
Street Address			
City	State	Zip	
Phone	Fax	Start Date	End Date
Practice Employer Name			

**Section 4: Work History (Continued)**

Street Address			
City	State	Zip	
Phone	Fax	Start Date	End Date

**Section 5: Work History Details**

Provide information on any gaps in your work history and include timeframes in month/year format.

**Section 6: Practice Location and Specialty Information**

**TIP:** Your Individual Tax ID is assumed to be your Primary Tax ID unless you specify otherwise to the right. Billing NPI refers to the NPI that would be placed in Box 33a on a paper CMS 1500 claim form.

**IMPORTANT:** Include a copy of your W-9 for each Tax ID referenced in this application.

Provide either an individual SSN or Group/Federal Tax ID for your primary practice

Individual Tax ID (SSN) (XXX-XX-XXXX)	Group/Federal Tax ID (XX-XXXXXXX)
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Billing NPI that will be Submitted on Claims

**Section 6: Practice Location and Specialty Information (Continued)**

List Languages Spoken by Office Staff

Are Interpreters Available?  Yes  NoIs the Location Listed Below Handicap Accessible?  Yes  NoAre You Currently Practicing at the Address Below?  Yes  No

Start Date (MM/DD/YYYY)

Age Range of Patients Accepted

Primary Practicing Specialty at this Location

Display in Directory  Yes  NoBoard Certified Specialty?  Yes  No

Name of Certification Board

Initial Certification Date (MM/DD/YYYY)

Recertification Date (MM/DD/YYYY)

Expiration Date (MM/DD/YYYY)

Currently Accepting New Patients?\*  Yes  No

Physician/Group Practice Name to Appear in Directory (Do Not Abbreviate)

Group/Corporate Legal Name as it Appears on W-9, if Different From Above (Do Not Abbreviate)

Website Address (URL)

Practice Street Address

City

State

9-Digit Zip

Appointment Phone

Business Fax

Website URL

Mailing Address (If Different Than Above)

City

State

Zip

Check Address

City

State

Zip

Credentialing Contact Name

Email

Credentialing Mailing Address

Phone

City

State

Zip

**Section 6: Practice Location and Specialty Information (Continued)****Additional Practice Location 1**

List additional location that uses SAME TAX ID as listed above that you wish to have listed in BCBSND provider directory (will only be listed if directory display = Yes). Billing NPI refers to the NPI that would be placed in Box 33a on a paper CMS 1500 claim form (or corresponding electronic field). If more space is needed include additional documentation as an attachment.

Start Date (MM/DD/YYYY)		Primary Practicing Specialty at this Location	
Display in Directory <input type="checkbox"/> Yes <input type="checkbox"/> No		Billing NPI that will be Submitted on Claims	
Currently Accepting New Patients? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Physician/Group Practice Name to Appear in Directory (Do Not Abbreviate)			
Group/Corporate Legal Name as it Appears on W-9, if Different From Above (Do Not Abbreviate)			
Practice Street Address			
City		State	9-Digit Zip
Appointment Phone		Business Fax	Contact Email
Mailing Address (If Different From Above)			
City		State	Zip
Check Address (If Different From Above)			
City		State	Zip
<b>Additional Practice Location 2</b>			
Start Date (MM/DD/YYYY)		Primary Practicing Specialty at this Location	
Display in Directory <input type="checkbox"/> Yes <input type="checkbox"/> No		Billing NPI that will be Submitted on Claims	
Currently Accepting New Patients?* <input type="checkbox"/> Yes <input type="checkbox"/> No			
Physician/Group Practice Name to Appear in Directory (Do Not Abbreviate)			
Group/Corporate Legal Name as it Appears on W-9, if Different From Above (Do Not Abbreviate)			
Practice Street Address			
City		State	9-Digit Zip
Appointment Phone		Business Fax	Contact Email
Mailing Address (If Different From Above)			
City		State	Zip

### Section 6: Practice Location and Specialty Information (Continued)

Check Address (If Different From Above)

City	State	Zip
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### Section 7: Admitting Privileges

List all current hospitals/institutions for which you have admitting privileges. If none, check "N/A."

Name of Hospital/Institution	<input type="checkbox"/> N/A	Date Admitting Privileges were Granted (MM/DD/YYYY)
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Street Address		
City	State	Zip

Name of Hospital/Institution	<input type="checkbox"/> N/A	Date Admitting Privileges were Granted (MM/DD/YYYY)
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Street Address		
City	State	Zip

### Section 8: Professional Liability/Malpractice Insurance Carrier

Attach a current copy of malpractice/liability insurance certificate which includes the following: practitioner name, policy name, policy number, coverage dates, coverage amounts. **Credentialing application cannot be processed without this attachment.**

### Section 9: Disclosure Questions

Answer all questions. If a question does not apply, answer "No." **Provide a detailed explanation for any "Yes" answers to the questions below.** Attach additional documentation if necessary.

1	Do you currently have any physical impairment or disability that could, without reasonable accommodation, impede your ability to provide care according to accepted standards of professional performance or poses a threat to the health or safety of your patients?*	<input type="checkbox"/> Yes <input type="checkbox"/> No
2	Do you currently have any mental impairment or disability that could, without reasonable accommodation, impede your ability to provide care according to accepted standards of professional performance or poses a threat to the health or safety of your patients?*	<input type="checkbox"/> Yes <input type="checkbox"/> No
3	Do you currently have any substance abuse problems that could, without reasonable accommodation, impede your ability to provide care according to accepted standards of professional performance or poses a threat to the health or safety of your patients?*	<input type="checkbox"/> Yes <input type="checkbox"/> No
4	Have you received treatment for substance abuse related conditions in the past five years?*	<input type="checkbox"/> Yes <input type="checkbox"/> No
5	Have you ever been convicted of a felony, fraud, narcotics offense, moral, or any other type of ethical crime?*	<input type="checkbox"/> Yes <input type="checkbox"/> No
6	Has your license or certification to practice in any jurisdiction ever been limited, restricted, revoked, suspended, voluntarily relinquished, terminated, subjected to disciplinary action or otherwise acted upon in an adverse manner?*	<input type="checkbox"/> Yes <input type="checkbox"/> No
7	Have you ever been sanctioned or penalized by any hospital, licensing board, government entity or managed care organization?*	<input type="checkbox"/> Yes <input type="checkbox"/> No
8	Have you ever voluntarily or involuntarily refused or denied membership on a hospital medical staff?*	<input type="checkbox"/> Yes <input type="checkbox"/> No
9	Have your specific clinical privileges at a facility in any jurisdiction ever been denied, limited, suspended, diminished, revoked, withdrawn or denied renewal?*	<input type="checkbox"/> Yes <input type="checkbox"/> No
10	Have you ever been subjected to disciplinary action by any medical organization?*	<input type="checkbox"/> Yes <input type="checkbox"/> No

**Section 9: Disclosure Questions (Continued)**

11	Have you ever been subjected to any claim(s) or under investigation for unethical conduct?*	<input type="checkbox"/> Yes <input type="checkbox"/> No
12	Have you ever been the subject of a malpractice claim or are there currently pending malpractice claims, suits, settlements, arbitration proceedings, or complaints filed involving your professional practice? If yes, attach a copy of the claim(s).*	<input type="checkbox"/> Yes <input type="checkbox"/> No
13	Have any judgments been made against you or settlements by you in any malpractice claim?*	<input type="checkbox"/> Yes <input type="checkbox"/> No
14	Have you ever been denied liability insurance, in whole or in part, or has your policy ever been canceled, involuntarily restricted, denied renewal, or rated up because of the nature of volume of claims against you?*	<input type="checkbox"/> Yes <input type="checkbox"/> No
15	Has your DEA or state certificate controlled dangerous substance license ever been suspended or revoked?*	<input type="checkbox"/> Yes <input type="checkbox"/> No

**Section 10: Disclosure Question Details**

Disclosure Questions answered "Yes" require additional information for review during the Credentialing process. Please provide the question number along with as much detail as possible or attach documentation.



### Section 11: Additional Directory Location – If Tax ID is different from locations listed in Section 4

List additional practice location for directory. Billing NPI refers to the NPI that would be placed in Box 33a on a paper CMS 1500 claim form (or corresponding electronic field).

**IMPORTANT:** Include a copy of your W-9 for each Tax ID referenced in this application.

Individual Tax ID (SSN) (XXX-XX-XXXX)		Group/Federal Tax ID (XX-XXXXXXX)		Use: <input type="checkbox"/> Individual <input type="checkbox"/> Group	
Billing NPI that will be Submitted on Claims					
List Languages Spoken by Office Staff					
Are Interpreters Available? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Is the Location Listed Below Handicap Accessible? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Are You Currently Practicing at the Address Below? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Start Date (MM/DD/YYYY)		Age Range of Patients Accepted		Currently Accepting New Patients?* <input type="checkbox"/> Yes <input type="checkbox"/> No	
Primary Practicing Specialty at this Location					
Display in Directory? <input type="checkbox"/> Yes <input type="checkbox"/> No			Board Certified Specialty? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Name of Certification Board					
Initial Certification Date (MM/DD/YYYY)		Recertification Date (MM/DD/YYYY)		Expiration Date (MM/DD/YYYY)	
Physician/Group Practice Name to Appear in Directory (Do Not Abbreviate)					
Group/Corporate Legal Name as it Appears on W-9, if Different From Above (Do Not Abbreviate)					
Website Address (URL)					
Practice Street Address					
City		State		9-Digit Zip	
Appointment Phone		Business Fax		Website URL	
Mailing Address (If Different Than Practice Street Address)					
City		State		Zip	
Check Address					
City		State		Zip	

## Behavioral Health Providers Capability/Services

**Capabilities** (Please check those capabilities in which you are certified or have received specific or on-going training. These may or may not be a covered benefit)

<input type="checkbox"/> ADD/ADHD	<input type="checkbox"/> Dual Diagnosis	<input type="checkbox"/> Parenting Skills
<input type="checkbox"/> Addictions	<input type="checkbox"/> Eating Disorders	<input type="checkbox"/> Pastoral Counseling
<input type="checkbox"/> Adoption Issues	<input type="checkbox"/> Electro-Convulsive Therapy (ECT)	<input type="checkbox"/> Personality Disorder
<input type="checkbox"/> Anger Management	<input type="checkbox"/> Faith Based Counseling	<input type="checkbox"/> Pervasive Development Disorders
<input type="checkbox"/> Anxiety Disorder	<input type="checkbox"/> Family Therapy	<input type="checkbox"/> Phobias
<input type="checkbox"/> Applied Behavior Analysis	<input type="checkbox"/> Forensic/Sex Offenders	<input type="checkbox"/> Physical abuse/violence
<input type="checkbox"/> Asperger's Syndrome	<input type="checkbox"/> Gay/Lesbian Identified Children	<input type="checkbox"/> Physically impaired patients
<input type="checkbox"/> Autism	<input type="checkbox"/> Grief Counseling	<input type="checkbox"/> Play therapy
<input type="checkbox"/> Behavior Modification	<input type="checkbox"/> Group Therapy	<input type="checkbox"/> Police personnel
<input type="checkbox"/> Bi-Polar Disorder	<input type="checkbox"/> Head Injury Patients	<input type="checkbox"/> Post Partum Depression
<input type="checkbox"/> Biofeedback	<input type="checkbox"/> Hearing Impaired issues	<input type="checkbox"/> Post Traumatic Stress Disorder
<input type="checkbox"/> Child Abuse	<input type="checkbox"/> HIV Positive/AIDS Patients	<input type="checkbox"/> Psych. Disability Eval/Mgmt
<input type="checkbox"/> Christian Counseling	<input type="checkbox"/> Home Care/Home Visits	<input type="checkbox"/> Psychological Testing
<input type="checkbox"/> Chronic Mental Illness	<input type="checkbox"/> Hypnosis	<input type="checkbox"/> Psychosomatic
<input type="checkbox"/> Chronic Physical Illness	<input type="checkbox"/> Independent Qualified/Medical Ex	<input type="checkbox"/> Psychotic Disorders
<input type="checkbox"/> Co-dependency	<input type="checkbox"/> Infertility	<input type="checkbox"/> Rape Issues
<input type="checkbox"/> Cognitive Behavioral Therapy	<input type="checkbox"/> Inpatient Therapy	<input type="checkbox"/> Rape Victims
<input type="checkbox"/> Compulsive Gambling	<input type="checkbox"/> Learning Disabilities	<input type="checkbox"/> Schizophrenic Disorders
<input type="checkbox"/> Conduct/Disruptive Disorders	<input type="checkbox"/> Medical Stress/Behavioral Med	<input type="checkbox"/> Sex Offender
<input type="checkbox"/> Couples/Marriage Therapy	<input type="checkbox"/> Medication Management	<input type="checkbox"/> Sexual abuse/violence
<input type="checkbox"/> Crisis Diversionary Services	<input type="checkbox"/> Men's Issues	<input type="checkbox"/> Sexual Dysfunction
<input type="checkbox"/> Crisis Intervention Svcs	<input type="checkbox"/> Mood disorders	<input type="checkbox"/> Sexual Harassment
<input type="checkbox"/> Critical Incident Debriefing	<input type="checkbox"/> Multicultural Issues	<input type="checkbox"/> Sexual Identity Issues
<input type="checkbox"/> Depressive Disorder	<input type="checkbox"/> Neuropsych Assessment	<input type="checkbox"/> Sleep Disorders
<input type="checkbox"/> Developmental Disabilities	<input type="checkbox"/> Nursing Home Visits	<input type="checkbox"/> Somatoform Disorders
<input type="checkbox"/> Dialectical Behavioral Therapy	<input type="checkbox"/> Obesity Assessment/Counseling	<input type="checkbox"/> Substance Abuse
<input type="checkbox"/> Disability Evaluation	<input type="checkbox"/> Obsessive Compulsive Disorder	<input type="checkbox"/> Terminally Ill patients
<input type="checkbox"/> Dissociative Disorder	<input type="checkbox"/> Organic Brain Syndrome	<input type="checkbox"/> Visually Impaired patients
<input type="checkbox"/> Divorce	<input type="checkbox"/> Pain Management	<input type="checkbox"/> Weapons Clearance
<input type="checkbox"/> Domestic Violence	<input type="checkbox"/> Panic Disorder	<input type="checkbox"/> Women's Issues

**Section 12: Consent to the Inspection of Records and Documents Release of Information and Liability Certification/Attestation**

I, \_\_\_\_\_ (print name\*) hereby authorize BLUE CROSS BLUE SHIELD OF NORTH DAKOTA (BCBSND), its professional staff and legal representatives, to contact and consult with administrators and members of the professional staff of any treatment facility, institution, professional society, school, employer, law enforcement agency, or practice with which I have been associated, for the purpose of evaluating my professional competence, character, criminal history and ethical conduct. In addition, I consent to the inspection of all records and documents, including health records at other treatment facilities that may be material for evaluation of my professional qualifications by BCBSND, its professional staff and legal representatives. I release from liability all individuals or organizations for acts performed in good faith and without malice honestly initiated and in response to the inquiries authorized for use by BCBSND. I agree that a photocopy of this authorization may be accepted with the same authority as the original.

I certify and attest to the fact that all of the information I have submitted in this application is true and accurate to the best of my knowledge and belief.

Signature	Date (MM/DD/YYYY)
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**Section 13: Credentialing Contact Information**

Application Completed by (Name)*			
Credentialing Contact Name (If Different Than Above)			
Mailing Address for Credentialing Correspondence			
Street*	City*	State*	Zip*
Email*	Phone	Fax	

**If you are having difficulty submitting the form once completed, please send using one of the following methods:**

- **Email:**
  - Click on "File" at the top of your screen
  - Click on "Save As"
  - Save the completed form on your computer
  - Attach the completed form to an email and send to [providerforms@bcbsnd.com](mailto:providerforms@bcbsnd.com)
- **Fax: 701-282-1910**
- **Mail: 4510 13th Ave. S.  
Fargo, ND 58121**