## **Public Health Unit Check List and Credentialing Application**



Please complete every section of the attached form. The following list may be used as a reference to assist you with the application. Recredentialing is conducted every three years and unless you are notified, participation will remain effective with no gaps.

Facility Information

Malpractice/Liability Insurance: Attach the malpractice insurance certificate or face sheet and evidence on letterhead (e.g. roster, letter, or fax) which clearly states that the provider, facility, or institution is covered by the insurance policy. The face sheet will also need to include the name of insurance company, from and through dates, policy number, and occurrence/aggregate amounts.

Signed Attestation

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

Federal TIN  Taxonomy Code  Street, City, State, Zip)  Billing/Mailing Address (Street, City, State, Zip)  (If different from physical address)  Street  State Zip City State Zip  Office Fax #  Billing Phone #  Billing Fax #					
Taxonomy Code  Street, City, State, Zip)  Billing/Mailing Address (Street, City, State, Zip) (If different from physical address) Street  State Zip City State Zip	<b>Public Health Unit Informa</b>	ation (Please complete a separate	e application for each location)		
Street, City, State, Zip)  Billing/Mailing Address (Street, City, State, Zip) (If different from physical address)  Street  State Zip City State Zip	Name of Facility		Federal TIN		
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Date Business Opened Name and Title of Chief Administrator	Type of Facility/Ownership		Organizational Structure		
Date Business Opened Name and Title of Chief Administrator	Government (Federal, State, County, City)		Corporation	Public Agency	
Date Business Opened  Name and Title of Chief Administrator  Organizational Structure	Private Non-Profit		Partnership	Group Practice Assoc.	
Date Business Opened  Name and Title of Chief Administrator  Organizational Structure  I, State, County, City)  Public Agency	Private For Profit		Single Owner	Professional Corporation	
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Date Business Opened  Name and Title of Chief Administrator  Organizational Structure  I, State, County, City)  Organizational Structure  Public Agency  Partnership  Group Practice Assoc.  Single Owner  Professional Corporation	Attach copy of malpractice face sheet.				
	Business Office Contact Name  NPI Number  Date Business Opened  Type of Facility/Ownership		Business Office Email Address  Name and Title of Chief Admini  Organizational Structure	istrator	
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Date Business Opened  Name and Title of Chief Administrator  Organizational Structure  I, State, County, City)  Organizational Structure  Public Agency Partnership Group Practice Assoc. Single Owner  Insurance	Attach copy of malpractice face sheet.				

## **Release and Attestation**

The undersigned is authorized to act on behalf of the institution/facility (Entity), and certifies that all information submitted on this application and all attachments hereto are correct, true and complete to the best of my knowledge.

The Entity consents to complete disclosure of and authorization to make available to Blue Cross Blue Shield of North Dakota (BCBSND), its affiliates or any of their agents, all relevant information pertaining to and deemed necessary and appropriate in the investigation and processing of this application, including but not limited to, information obtained through a third party such as an insurance company, licensing authority, accrediting agency or governmental agency.

The Entity releases and discharges BCBSND, its affiliates and their representatives, credentials committees, administrators, governing bodies, agents, employees and all other persons or entities supplying information to them, from liability or claims of any kind or character in any way arising out of inquiries or disclosures made in good faith in connection with this application.

The Entity agrees to update this application while it is being processed should there be any change in the information provided regarding the Entity that could affect the application or its outcome. A photocopy of this document shall be as effective as the original.

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Name (Print or Type)	Title		
Signature	Date (MM/DD/YYYY)		

## **SUBMIT INSTRUCTIONS**

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

- Email (Please follow these steps):
  - 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
- Fax: 701-282-1910
- Mail: 4510 13th Ave S Fargo, ND 58121