Behavioral Health – Institutional Provider Credentialing Application for UB Claim Submission

Only psychiatric PHP and IOP facilities are required to attest to the appropriate corresponding program criteria attached.

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

- Email: providerforms@bcbsnd.com
- Fax: 701-282-1910
- Mail: Blue Cross Blue Shield of North Dakota
  4510 13th Ave. S.
  Fargo, ND 58121

If you have any questions, please send an email to prov.net@bcbsnd.com.

Institutional Provider Type *(Place a check next to ALL correct classifications)*

Psychiatric	**Substance Use**
☐ Residential Treatment Center (RTC)	☐ Residential Treatment Center (RTC)
☐ Partial Hospitalization Program (PHP)	☐ Partial Hospitalization Program (PHP)
☐ Intensive Outpatient Program (IOP)	☐ Intensive Outpatient Program (IOP)
Hospital	
☐ Psychiatric Hospital	

Institutional Provider Information *(Please complete a separate application for each practicing location)*

Name of Facility		Federal TIN	
NPI		Effective Date of Group	
Physical Street Address Street City State Zip		Billing/Mailing Address (*If different from physical address*) Street City State Zip	
Patient Appointment Phone Number	Office Fax Number	Billing Phone Number	Billing Fax Number
Website Address		Non-English Languages Spoken by Clinical Staff	
Credentialing Contact Name and Phone Number		Credentialing Contact Email	
Name and Title of Chief Administrator		Total Licensed Bed Capacity	

Facility accepts *(Check all that apply):* ☐ Credit Card ☐ Debit Card ☐ Neither

Current License/Certificate *(Attach a current copy of all licenses and certificates that apply)*

Issued By	Current State License Or Certification Number	Original Issue Date *(MM/DD/YYYY)*	Expiration Date *(MM/DD/YYYY)*
State			
Medicare Certification Number			

BND-25-0931801A • 8-25

Current License/Certificate *(Attach a current copy of all licenses and certificates that apply)*

Issued By	Current State License Or Certification Number	Original Issue Date *(MM/DD/YYYY)*	Expiration Date *(MM/DD/YYYY)*
Medicaid			
Joint Commission Accreditation or other CMS-approved accreditation with deeming authority			
Other			

Malpractice/Liability Insurance

Attach a copy of malpractice insurance 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 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.

I consent to the use of an electronic signature and understand that by typing my name in the signature space within the Consent section of this application, I am affixing my electronic signature which has the same legal effect and enforceability as my handwritten signature. 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 complete, true, and accurate to the best of my knowledge and belief.

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

BND-25-0931801A • 8-25

Psychiatric - Partial Hospitalization Program (PHP) *(Please attest that your psychiatric program meets substance use licensing criteria below in lieu of ND state license)*

- Offers structured therapeutic program at least 20 hours per week (30 hours per week for eating disorders) (can consist of individual therapy, family therapy, group therapy and psychoeducation)
- Provides care coordination with other providers and social services.
- Documents clinical assessment at least once per program day.
- Documents individualized goal directed treatment plan.
- Documents medication reconciliation initiated within first program day.
- Documents psychiatric or medication evaluation and least once per week.
- Documents psychosocial assessment within first visit.
- Documents substance evaluations within the first three (3) program days (InterQual indicates within first two (2) program days) and then weekly.
- Provides toxicology screen as needed.
- Offers self-help, 12-step education or recovery group at least one (1) hour per day, at least three (3) times per week

I attest that the Institution/Facility below meets all of the above program criteria.

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

BND-25-0931801A • 8-25

Intensive Outpatient Program (IOP) *(Please attest that your psychiatric program meets substance use licensing criteria below in lieu of ND state license)*

- Offers structured therapeutic program at least nine (9) hours per week or six (6) hours per week for adolescents (can consist of individual therapy, family therapy, group therapy and psychoeducation).
- Provides care coordination with other providers and social services.
- Documents individualized goal directed treatment plan.
- Documents medication reconciliation initiated within first week.
- Documents psychiatric or medication evaluation as needed.
- Documents psychosocial assessment within first visit.
- Documents substance evaluations within the two (2) visits and weekly.
- Provides toxicology screen as needed.
- Offers self-help, 12-step education or recovery group at least one (1) hour per day, at least two (2) days per week

I attest that the Institution/Facility below meets all of the above program criteria.

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

BND-25-0931801A • 8-25