Medication-Assisted Treatment Facility Credentialing Application

Instructions: All providers should complete Sections A and B. Complete the portions the sections that apply to your organization by attesting to the program requirements outlined in this form.

If you are having difficulty 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

Section A: Program Type *(Place a check next to ALL correct classifications)*

☐ Opioid Treatment Program
☐ Office-Based Opioid Treatment

Section B: Provider Information

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

Name of Facility	Federal TIN
NPI	Effective Date of Group *(MM/DD/YYYY)*
Website Address *(URL)*	List Languages Spoken by Clinical Staff
Physical Street Address Street City State Zip	Billing/Mailing Address (*If different from physical address*) Street City State Zip

Patient Appointment Phone	Office Fax	Billing Phone	Billing Fax
Business Office Contact Name and Phone		Business Office Contact Email	
Name and Title of Chief Administrator			

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

Malpractice/Liability Insurance

Attach the malpractice insurance face sheet and evidence (e.g. roster, letter, fax) that clearly states the name of provider being credentialed and covered under your insurance policy. The face sheet must also contain the name of insurance company, from and through dates, policy number and occurrence/aggregate coverage amounts.

Did you attach copy of malpractice insurance face sheet? ☐ Yes ☐ No

BND-25-0977123 • 6-25

Malpractice/Liability Insurance *(Continued)*

Opioid Treatment Program Current License / Certification *(Attach a current copy licenses and certificates)*

	State	Current State License, Certification Number	Original Issue Date (*MM/DD/YYYY*)	Expiration Date (*MM/DD/YYYY*)
State License (Nonprovisional)				
SAMHSA Opioid Treatment Program Certification				
DEA				
Medicaid				

Release and Attestation

The undersigned is authorized to act on behalf of the institution (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.

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-25-0977123 • 6-25