Ambulance Recredentialing Application

All providers are required to attest to the appropriate corresponding program criteria attached. Recredentialing is conducted every three years and unless you are notified, participation will remain effective with no gaps.

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

Ambulance Facility Information *(Please complete a separate application for each location)*			
Name of Ambulance Facility		Federal TIN	Taxonomy Code
Physical Street Address (Street, City, State, Zip) Street City State Zip		Billing/Mailing Address (Street, City, State, Zip) *(If different from physical address)* Street City State Zip	
Office Phone #	Office Fax #	Billing Phone #	Billing Fax #
Office Staff Foreign Languages ☐ Speak ☐ Read ☐ Write ☐ N/A			
Business Office Contact Name		Business Office Email Address	
NPI Number	Date Business Opened	Name and Title of Chief Administrator	
Type of Facility/Ownership ☐ Government (Federal, State, County, City) ☐ Private Non-Profit ☐ Private For Profit ☐ Other:		Organizational Structure ☐ Corporation ☐ Partnership ☐ Single Owner ☐ Public Agency ☐ Group Practice Assoc. ☐ Professional Corporation	
Does Ambulance Facility Accept (*Check all that apply*) ☐ Credit Card ☐ Debit Card ☐ Neither			

Current License(s)

State	Current License Number	Original Issue Date	Expiration Date

Blue Cross Blue Shield of North Dakota is an independent licensee of the Blue Cross & Blue Shield Association

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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.

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

Please double check that the application is complete.

SUBMIT FORM

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