Ambulance Recredentialing Application

Instructions: 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 email to prov.net@bcbsnd.com.

Submission instructions: 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

Liability insurance: All providers are required to submit with this form a copy of liability certificate or letter from insurance provider.

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
Website Address *(URL)*		List Languages Spoken by Clinical Staff	
Office Staff Foreign Languages	☐ Speak ☐ Read ☐ Write ☐ N/A		
Business Office Contact Name		Business Office Email	
NPI Number		Date Business Opened *(MM/DD/YYYY)*	
Name and Title of Chief Administrator			

Type of Facility/Ownership	Organizational Structure	
☐ Government (Federal, State, County, City)	☐ Corporation	☐ Public Agency
☐ Private Non-Profit	☐ Partnership	☐ Group Practice Association
☐ Private For Profit	☐ Single Owner	☐ Professional Corporation
☐ Other:		

Does Ambulance Facility Accept (*Check all that apply*) ☐ Credit Card ☐ Debit Card ☐ Neither

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Current License(s)

State	Current License Number	Original Issue Date	Expiration Date

Liability Insurance (Required)

Attached is a copy of the liability certificate or letter from insurance provider ☐ Yes

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.

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)*

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