Durable Medical Equipment (DME) Facility Checklist and Recredentialing 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.

- ☐ **DME 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**
- ☐ **Requirements:** Medicare Certification or Medicare Participation. Notify Blue Cross Blue Shield of North Dakota (BCBSND) of any changes to your Medicare status as it may affect your credentialing and/or continued participation.

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

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

DME Facility Information *(Please complete a separate application for each location)*			
Name of Facility		Federal TIN	
Medicare Certification Number or Medicare Participation Number		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 ☐ Government (Federal, State, County, City) ☐ Private Non-Profit ☐ Private For Profit ☐ Other:		Organizational Structure ☐ Corporation ☐ Partnership ☐ Single Owner ☐ Public Agency ☐ Group Practice Association ☐ Professional Corporation	

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Malpractice/Liability Insurance

Attach copy of malpractice certificate or 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.

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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