Practitioner Recredentialing Application

Instructions: Recredentialing is conducted every 3 years. Once this application has been submitted, unless you hear otherwise, your continued participation obligations have been met. Read all instructions carefully prior to submitting your application.

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

Section 1: Personal Information *(Note: BCBSND may use this method for application follow-up)*

Name (Do not use nicknames or initials, unless they are part of your legal name)

Last Name	First Name	Middle Name	Suffix

Credential	National Provider Identification (NPI) Number

Have you ever used another name? ☐ Yes ☐ No

If yes, please list all other names used and their dates of use — Dates other name was used

Other Last Name	Other First Name	Date Started	End Date

Email	Phone	Fax

Section 2: Practice Location and Specialty Information

IMPORTANT: Include a copy of your W-9 if your Tax ID or practice name has changed from what was submitted previously. If you have moved or changed employment, complete the Supplemental Additional Location form. Claims may be impacted if this information is not communicated.

Provide either an individual SSN or Group/Federal Tax ID for your primary practice

Individual Tax ID (SSN) (XXX-XX-XXXX)	Group/Federal Tax ID (XX-XXXXXXX)	Use: ☐ Individual ☐ Group

Billing NPI that is Submitted on Claims	Name of Practice

Primary Practicing Specialty at this Location

Board certified specialty? ☐ Yes ☐ No

Name of Certification Board

Initial Certification Date (MM/DD/YYYY)	Recertification Date (MM/DD/YYYY)	Expiration Date (MM/DD/YYYY)

Group/Corporate Legal Name as it Appears on W-9

Section 3: Professional IDs

Include all state licenses, DEA Registrations and SAMHSA waivers.

IMPORTANT: DEA registration should match the state in which you work. Provide all current and previous licenses/certifications.

Federal DEA Number ☐ N/A

SAMHSA DEA Number	State of Registration

DEA Issue Date (MM/DD/YYYY)	DEA Expiration Date (MM/DD/YYYY)

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

29380110 • 5-20

Section 3: Professional IDs *(Continued)*

License Number	License Issuing State
License Issue Date (MM/DD/YYYY)	License Expiration Date (MM/DD/YYYY)
Are you currently practicing in this state? ☐ Yes ☐ No	
License Number	License Issuing State
License Issue Date (MM/DD/YYYY)	License Expiration Date (MM/DD/YYYY)
Are you currently practicing in this state? ☐ Yes ☐ No	
License Number	License Issuing State
License Issue Date (MM/DD/YYYY)	License Expiration Date (MM/DD/YYYY)
Are you currently practicing in this state? ☐ Yes ☐ No	

Other ID Numbers *(Note: Healthy Steps providers must be enrolled with Medicaid)*

Are you a participating Medicare provider? ☐ Yes ☐ No	Medicare Number	
Are you a participating Medicaid provider? ☐ Yes ☐ No	Medicaid Number	Medicaid State

Section 4: Credentialing Contact Information

Application Completed by (Name)			
Credentialing Contact Name (If Different Than Above)			
Mailing Address for Credentialing Correspondence Street	City	State	Zip
Email	Phone	Fax	

Section 5: Professional Liability/Malpractice Insurance Carrier

Attach a current copy of malpractice/liability insurance certificate which includes the following: practitioner name, policy name, policy number, coverage dates, coverage amounts. **Credentialing application cannot be processed without this attachment.**

Section 6: Disclosure Questions *Pertaining to Only the Past 3 Years*

Answer all questions. For any "Yes" response, provide an explanation on the supplemental Disclosure Question Explanation Form in Section 8. If question does not apply, answer "No."

1	Has your license or certification to practice in any jurisdiction been limited, restricted, revoked, suspended, voluntarily relinquished, terminated, subjected to disciplinary action or otherwise acted upon in an adverse manner?	☐ Yes ☐ No
2	Have you been sanctioned or penalized by any hospital, licensing board, government entity or managed care organization?	☐ Yes ☐ No
3	Have you voluntarily or involuntarily refused or denied membership on a hospital medical staff?	☐ Yes ☐ No
4	Have your specific clinical privileges at a facility in any jurisdiction ever been denied, limited, suspended, diminished, revoked, withdrawn or denied renewal?	☐ Yes ☐ No
5	Have you been subjected to disciplinary action by any medical organization?	☐ Yes ☐ No
6	Have you been subjected to any claim(s) or under investigation for unethical conduct?	☐ Yes ☐ No
7	Has your DEA license or narcotics registration ever been suspended or revoked?	☐ Yes ☐ No

Section 6: Disclosure Questions *Pertaining to Only the Past 3 Years* *(Continued)*

Answer all questions. For any "Yes" response, provide an explanation on the supplemental Disclosure Question Explanation Form in Section 8. If question does not apply, answer "No."

#	Question	Answer
8	Have you been the subject of a malpractice claim or are there currently pending malpractice claims, suits, settlements, arbitration proceedings, or complaints filed involving your professional practice?	☐ Yes ☐ No
9	Have any judgments been made against you or settlements by you in any malpractice claim?	☐ Yes ☐ No
10	Have you been denied liability insurance, in whole or in part, or has your policy been canceled, involuntarily restricted, denied renewal, or rated up because of the nature of volume of claims against you?	☐ Yes ☐ No
11	Has your employer changed in the past 3 years?	☐ Yes ☐ No
12	Has your board status changed in the past 3 years? If yes, list specialty: 1st Specialty ______ 2nd Specialty ______	☐ Yes ☐ No
13	Have you been convicted of a felony, fraud, narcotics offense, moral, or any other type of ethical crime?	☐ Yes ☐ No

Section 7: Supplemental Form – Disclosure Question Details

Disclosure Questions answered "Yes" require additional information for review during the Recredentialing process. Please provide the question number along with as much detail as possible or attach documentation.

Section 8: Patient Population Served

Please Identify The Age Range And Gender Of Patients Served *(Check all that apply)*

☐ Preschool 0-5 ☐ Adolescent 13-17 ☐ Geriatrics 65+ ☐ Female Patients
☐ Children 6-12 ☐ Adults 18-65 ☐ Male Patients

Is provider currently accepting new patients? ☐ Yes ☐ No

Section 9: Behavioral Health Providers Capability/Services

Please check those capabilities in which you are certified or have received specific or on-going training. These may or may not be a covered benefit.

- ☐ ADD/ADHD
- ☐ Addictions
- ☐ Adoption Issues
- ☐ Anger Management
- ☐ Anxiety Disorder
- ☐ Applied Behavior Analysis
- ☐ Asperger's Syndrome
- ☐ Autism
- ☐ Behavior Modification
- ☐ Bi-Polar Disorder
- ☐ Biofeedback
- ☐ Child Abuse
- ☐ Christian Counseling
- ☐ Chronic Mental Illness
- ☐ Chronic Physical Illness
- ☐ Co-Dependency
- ☐ Cognitive Behavioral Therapy
- ☐ Compulsive Gambling
- ☐ Conduct/Disruptive Disorders
- ☐ Couples/Marriage Therapy
- ☐ Crisis Diversionary Services
- ☐ Crisis Intervention Services
- ☐ Critical Incident Debriefing
- ☐ Depressive Disorder
- ☐ Developmental Disabilities
- ☐ Dialectical Behavioral Therapy
- ☐ Disability Evaluation
- ☐ Dissociative Disorder
- ☐ Divorce
- ☐ Domestic Violence
- ☐ Dual Diagnosis
- ☐ Eating Disorders
- ☐ Electro-Convulsive Therapy (ECT)
- ☐ Faith Based Counseling
- ☐ Family Therapy
- ☐ Forensic/Sex Offenders
- ☐ Gay/Lesbian Identified Children
- ☐ Grief Counseling
- ☐ Group Therapy
- ☐ Head Injury Patients
- ☐ Hearing Impaired Issues
- ☐ HIV Positive/AIDS Patients
- ☐ Home Care/Home Visits
- ☐ Hypnosis
- ☐ Independent Qualified/Medical Ex
- ☐ Infertility
- ☐ Inpatient Therapy
- ☐ Learning Disabilities
- ☐ Medical Stress/Behavioral Med
- ☐ Medication Management
- ☐ Men's Issues
- ☐ Mood Disorders
- ☐ Multicultural Issues
- ☐ Neuropsych Assessment
- ☐ Nursing Home Visits
- ☐ Obesity Assessment/Counseling
- ☐ Obsessive Compulsive Disorder
- ☐ Organic Brain Syndrome
- ☐ Pain Management
- ☐ Panic Disorder
- ☐ Parenting Skills
- ☐ Pastoral Counseling
- ☐ Personality Disorder
- ☐ Pervasive Development Disorders
- ☐ Phobias
- ☐ Physical Abuse/Violence
- ☐ Physically Impaired Patients
- ☐ Play Therapy
- ☐ Police Personnel
- ☐ Post Partum Depression
- ☐ Post Traumatic Stress Disorder
- ☐ Psych. Disability Eval/Mgmt
- ☐ Psychological Testing
- ☐ Psychosomatic
- ☐ Psychotic Disorders
- ☐ Rape Issues
- ☐ Rape Victims
- ☐ Schizophrenic Disorders
- ☐ Sex Offender
- ☐ Sexual Abuse/Violence
- ☐ Sexual Dysfunction
- ☐ Sexual Harassment
- ☐ Sexual Identity Issues
- ☐ Sleep Disorders
- ☐ Somatoform Disorders
- ☐ Substance Abuse
- ☐ Terminally Ill Patients
- ☐ Visually Impaired Patients
- ☐ Weapons Clearance
- ☐ Women's Issues

Section 10: Malpractice/Liability Insurance

Attach A Copy Of Malpractice/Liability Insurance Face Sheet.

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.

Section 11: Consent to the Inspection of Records and Documents Release of Information and Liability Certification/Attestation

I, ____ (print name) hereby authorize BLUE CROSS BLUE SHIELD OF NORTH DAKOTA (BCBSND), its professional staff and legal representatives, to contact and consult with administrators and members of the professional staff of any treatment facility, institution, professional society, school, employer, law enforcement agency, or practice with which I have been associated, for the purpose of evaluating my professional competence, character, criminal history and ethical conduct. In addition, I consent to the inspection of all records and documents, including health records at other treatment facilities that may be material for evaluation of my professional qualifications by BCBSND, its professional staff and legal representatives. I release from liability all individuals or organizations for acts performed in good faith and without malice honestly initiated and in response to the inquiries authorized for use by BCBSND. 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 true and accurate to the best of my knowledge and belief.

Signature	Date (MM/DD/YYYY)

Supplemental Additional Location Form on next page.

Please double check that the application is complete.

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

- **Email:**
  - **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

Supplemental Additional Location Form

Supplemental form to Practitioner Recredentialing Application. This form is not to be used to replace any other documentation.

Provider Information	
Provider Name	NPI
Specialties	

Additional Location Information		
Business/Corporation Name		Organization NPI
Practicing Address Street	Billing/Mailing Address (*If different from practicing address*) Street	
City State Zip	City State Zip	
Is this the Primary Practice Location for this Provider? ☐ Yes ☐ No		
Should this provider display in the directory? ☐ Yes ☐ No		
Accepting new patients? ☐ Yes ☐ No		
Patient Appointment Phone #	Clinic Telephone #	Provider Phone # (*If different from clinic*)
Tax Identification Number (TIN)		Effective Date

Additional Location Information		
Business/Corporation Name		Organization NPI
Practicing Address Street	Billing/Mailing Address (*If different from practicing address*) Street	
City State Zip	City State Zip	
Is this the Primary Practice Location for this Provider? ☐ Yes ☐ No		
Should this provider display in the directory? ☐ Yes ☐ No		
Accepting new patients? ☐ Yes ☐ No		
Patient Appointment Phone #	Clinic Telephone #	Provider Phone # (*If different from clinic*)
Tax Identification Number (TIN)		Effective Date

29380110 • 5-20