Recredentialing Application Institution/Facility

Recredentialing is conducted every three years and unless you are notified, your participation will remain effective with no gaps.

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

- Email: providerforms@bcbsnd.com
- Mail: Blue Cross Blue Shield of North Dakota
  4510 13th Ave. S.
  Fargo, ND 58121
- Fax: 701-282-1910

Facility/Agency Type *(Place a check next to ALL correct classifications)*

- ☐ Ambulatory Surgery Center
- ☐ Diabetes Prevention Program
- ☐ Dialysis/Kidney Center
- ☐ Free Standing Radiology/Portable X-Ray Supplier
- ☐ General Hospital (Short Term)
- ☐ General Hospital (Long Term)
- ☐ Hearing Aid Supplier
- ☐ Home Health Agency
- ☐ Hospice
- ☐ Laboratory (Independent or Hospital-Based)
- ☐ Rehabilitation Facility
- ☐ Skilled Nursing Facility
- ☐ Swing Bed
- ☐ Urgent Care
- ☐ Other (Description):

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

Name of Facility	Federal TIN
NPI	Effective Date of Group *(MM/DD/YYYY)*
Taxonomy Code	Display in Directory ☐ Yes ☐ No
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
Patient Appointment 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
Is the Facility Certified as a National Disaster Medical System (NDMS)? ☐ Yes ☐ No	
Name and Title of Chief Administrator	Total Licensed Bed Capacity
Facility Accepts *(Check all that apply)* ☐ Credit Card ☐ Debit Card ☐ Neither	

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

Trauma Level

- ☐ I – All Complex Injuries
- ☐ II – Severe Trauma
- ☐ III – Common Trauma w/o specialized care
- ☐ IV – Routine Care
- ☐ V – Routine Care – May not be 24/7
- ☐ 0 – No Trauma Care

Current License/Certificate *(Attach a current copy of all licenses and certificates that apply)*

Issued By	Current State License Or Certification Number	Original Issue Date *(MM/DD/YYYY)*	Expiration Date *(MM/DD/YYYY)*
State			
Medicare Certification Number			
Medicaid			
The Joint Commission			
CARF (Commission On Accreditation of Rehabilitation Facilities)			
AAAASF (American Association for Accreditation of Ambulatory Surgery Facilities)			
AAAHC (Accreditation Assoc. for Ambulatory Health Care, Inc.)			
Other			

Malpractice/Liability Insurance

Attach a copy of malpractice insurance 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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