Capital BLUE

Capital BlueCross
Facility Provider Application

PROVIDER INFORMATION		
Provider/Practice Name:	Organization/Legal Name:	List all Taxonomy codes:
Medicare Provider Number:	Medicaid Promise ID:	National Provider Identifier (NPI type 2):

CONTACTS:

Administrator/CEO: Role: Phone: ( ) - ext. Fax: ( ) - ext. Email:	Pres. Medical Staff: Role: Phone: ( ) - ext. Fax: ( ) - ext. Email:
CFO: Role: Phone: ( ) - ext. Fax: ( ) - ext. Email:	Business Office Manager: Role: Phone: ( ) - ext. Fax: ( ) - ext. Email:
Controller: Role: Phone: ( ) - ext. Fax: ( ) - ext. Email:	UR Coordinator: Role: Phone: ( ) - ext. Fax: ( ) - ext. Email:
QA Coordinator: Role: Phone: ( ) - ext. Fax: ( ) - ext. Email:	Manager of Admissions: Role: Phone: ( ) - ext. Fax: ( ) - ext. Email:
Dir. M.I.S.: Role: Phone: ( ) - ext. Fax: ( ) - ext. Email:	Hospital Physical Advisor: Role: Phone: ( ) - ext. Fax: ( ) - ext. Email:
Survey Response Contact: (Person best suited to respond to satisfaction surveys) Role: Phone: ( ) - ext. Fax: ( ) - ext. Email:	Medical Records Contact: (Person who is to receive Medical Record requests) Role: Phone: ( ) - ext. Fax: ( ) - ext. Email:
Contract Contact: Role: Phone: ( ) - ext. Fax: ( ) - ext. Email:	Value-Based Program Contact: Role: Phone: ( ) - ext. Fax: ( ) - ext. Email:

ADDRESSES:

Corporate Office: *(This is where we will mail your fully executed contract and certain legal notices)*

Street:		County:
City:	State:	ZIP Code:
Phone Number: ( ) ext.	Fax Number: ( ) ext.	
Provider Website Address:		
Email:	Office Hours:	

Primary Site Location:

Street:		County:
City:	State:	ZIP Code:
Phone Number: ( ) ext.	Fax Number: ( ) ext.	
Provider Website Address:		
Email:	Office Hours:	
Languages Spoken:	Handicap Accessibility: ❑ Yes ❑ No	

Correspondence: *(Please complete the Correspondence/Billing/Remit/Medical Records addresses below if it differs from the Primary Location)*

Street:		County:
City:	State:	ZIP Code:
Phone Number: ( ) ext.	Fax Number: ( ) ext.	
Provider Website Address:		
Email:		

❑ Click box if you have additional locations you provide services using the same NPI Number as above

Billing Address: *Business Office/Billing Office*

Name:		
Street or P.O. Box:		County:
City:	State:	ZIP Code:
Phone Number: ( ) ext.	Fax Number: ( ) ext.	
Website:		

Remit: *(This is where you want to receive payments)*

Name:		
Street or P.O. Box:		County:
City:	State:	ZIP Code:
Phone Number: ( ) ext.	Fax Number: ( ) ext.	

Medical Records:

Name:		
Street or P.O. Box:		County:
City:	State:	ZIP Code:
Phone Number: ( ) ext.	Fax Number: ( ) ext.	

MISCELLANEOUS INFORMATION:

Type of Organizational Structure: *(Attach a copy of a W-9)*

❑ Nonprofit Corporation ❑ Sole Proprietorship ❑ Partnership ❑ For-Profit Corporation

❑ Other (Please Explain): _____

_____

❑ Government

❑ Federal ❑ County ❑ State ❑ Other (Please Explain): _____

_____

❑ Submit a copy of your organizational chart of the provider as well as provider's placement within any broader corporate structure.

Additional Information:

❑ If sole proprietorship, a partnership, or for-profit corporation, submit a list with the names of the owners or major stockholders (more than five percent ownership).

❑ Submit a copy of the incorporation papers and bylaws, and if applicable, the fictitious name filing.

❑ Submit a list of provider's Board of Directors/Board of Trustees.

❑ Submit an organizational chart of the provider as well as provider's placement within any broader corporate structure.

Programs For Which You Are Applying for Contract With Capital BlueCross:

❑ Capital BlueCross ❑ *Traditional* ❑ Comprehensive	❑ Keystone Health Plan® Central (HMO) ❑ Commercial ❑ Medicare Advantage HMO	❑ CAIC/CAAC ❑ *Traditional* ❑ *PPO* ❑ *POS* ❑ Medicare Advantage PPO	❑ ALL Programs

Locations of Operation: *Please indicate the counties in which the facility/organization provides services (service area)*

❑ Adams ❑ Berks ❑ Centre ❑ Columbia ❑ Cumberland ❑ Dauphin ❑ Franklin	❑ Fulton ❑ Juniata ❑ Lancaster ❑ Lebanon ❑ Lehigh ❑ Mifflin ❑ Montour	❑ Northampton ❑ Northumberland ❑ Perry ❑ Schuylkill ❑ Snyder ❑ Union ❑ York	❑ Others (Please List) _____ _____ _____ _____ _____ _____

Provider Type: *Please check the block that best identifies your overall operation*

❑ Acute Care Hospital ❑ Rehabilitation Hospital ❑ Psychiatric Hospital ❑ Veterans Administration Hospital ❑ Outpatient Substance Abuse Center ❑ Substance Abuse Center (rehabilitation) ❑ Substance Abuse Center (detox) ❑ Long Term Acute Care Hospital	❑ Partial Psychiatric Provider ❑ Skilled Nursing Facility ❑ Home Health Agency *❑ Hospice—see page 10 ❑ Home Medical Equipment ❑ Ambulance ❑ Infusion Therapy ❑ Prosthetics and Orthotics ❑ Laboratory	**Outpatient Freestanding:** ❑ Radiation Therapy ❑ Diagnostic Services ❑ Birthing Center ❑ Ambulatory Surgical ❑ Renal Dialysis ❑ Rehabilitation (Physical Therapy, CORF) ❑ MRI ❑ Other - Please Specify: _____ _____

Description of Services: *Briefly describe the program and/or services offered by the provider*

Is the provider currently in operation? ❑ Yes ❑ No	If yes, what was the date it began operation?
If no, what is the scheduled date of opening?	What are the hours of operation?

If not 24 hours per day, seven days a week, please explain the coverage arrangement for patients to contact provider during nonbusiness hours:

Independent Lab: *(If not applicable, please skip this section and move to Certification/Accreditation)*

1. Do you have a contract with the BlueCross BlueShield Association (BCBSA)? ❑ Yes ❑ No

2. Do you have a current National Master Business Agreement (NMBA)? ❑ Yes ❑ No

3. Do you offer PROPRIETARY or SOLE SOURCE testing? ❑ Yes ❑ No

   If yes, what test(s)? _____

   Link to website with information supporting utility of the test: _____

4. Please provide a summary of how your lab offerings are differentiated in the marketplace.

5. Please answer what level of presence your lab has in our 21-county area, including both Capital BlueCross members and members with other Blue plans.

6. We require submission of a Proposed Coding Crosswalk and Proposed Fee Schedule with this application.

   Proposed Coding Crosswalk attached? ❑ Yes ❑ No Proposed Fee Schedule attached? ❑ Yes ❑ No

Certification/Accreditation: *Please respond to the following and include those items applicable to your organization*

1. Submit a current copy of the provider's state license(s) from the appropriate State Licensure Bureau(s) for all jurisdictions in which services are provided (i.e., the Department of Health, Department of Public Welfare, etc.)

   a. Please submit a copy of the latest state survey results.

2. Is the provider accredited by an independent accreditation agency such as the Joint Commission (JCAHO), the Accreditation Association for Ambulatory Health Care (AAAHC), the Community Health Accreditation Program (CHAP), American Osteopathic Association (AOA), Commission on Accreditation of Rehabilitation Facilities (CARF), Clinical Laboratory Improvement Amendment (CLIA) etc.?

   ❑ Yes ❑ No Accrediting Organization: _____

   a. If yes, please submit a copy of the accreditation letter certifying the dates of accreditation. Is the accreditation incorporated within another health care entity? ❑ Yes ❑ No If yes, specify the other entity _____

   b. If no, please submit a copy of the provider's application for accreditation, with the date of the planned survey, or advise the plans for achieving accreditation.

3. Please explain if the provider is certified as a provider in the Medicare and Medical Assistance Programs:

   Medicare ❑ Yes ❑ No
   Medical Assistance ❑ Yes ❑ No

   a. If yes for Medicare, please advise the following:

      1. Name of Medicare Intermediary: _____
         Please provide a copy of the CMS certification determination letter

      2. Effective date of Medicare participation: _____

   b. If yes for Medical Assistance, please provide the following:

      1. Effective date of Medical Assistance participation: _____
      2. Certificate of certification for Medical Assistance.

4. Has the facility, any corporate officer, or any agent acting on behalf of the facility, been investigated or convicted of abusive utilization, fraud, or malpractice for Medicare or Medical Assistance in the last five years?

   ❑ Yes ❑ No

   If yes, please explain: _____

   _____

   If yes, please furnish documentation concerning the dates of such investigation and a description of any action taken against the provider and the outcome (i.e., suspension and reinstatement under the program).

5. Does the facility, or its affiliates, employ any person in any capacity who is excluded from a federal health benefit program?

   ❑ Yes ❑ No

   If yes, please explain: _____

   _____

6. Does the facility make payments pursuant to a contract, or similar business arrangement, to any person or entity that is excluded from a federal health benefit program?

   ❑ Yes ❑ No

   If yes, please explain: _____

   _____

Certification/Accreditation: *(continued)*

7. Does the facility and its affiliates have a written policy which prohibits the facility and its affiliates from employing a person, or making payments pursuant to a business arrangement, to a person or entity, that is excluded from a federal health benefit program?

   ❑ Yes ❑ No

   If no, please explain:

   _____

   _____

   _____

8. Pursuant to the facility's employment agreements and business arrangements with independent contractors, do employees and independent contractors have a duty to give written notice to facility or its affiliates if the employee or independent contractor is excluded from a federal health benefit program?

   ❑ Yes ❑ No

   If no, please explain:

   _____

   _____

   _____

9. Has the facility, or any of its affiliates, entered into a corporate integrity agreement with any state or federal agency?

   ❑ Yes ❑ No

   If yes, please provide a copy to Capital BlueCross.

10. Has the provider had any revocation or suspension of license to provide health care by any state licensing authority?

    ❑ Yes ❑ No

    If yes, please explain and submit letter of reinstatement:

    _____

    _____

    _____

11. Submit a copy of the current face sheets for the provider's professional liability insurance, property insurance, and general liability insurance policies.

    Please indicate the types of liability insurance maintained by the facility:

    ❑ Property Insurance

    ❑ General Liability

    ❑ Professional Liability

    ❑ Other (Specify) _____

    Please advise if there have been within the last five (5) years, or are pending, any claims made or settlements for malpractice or negligence in the provisions of services, or disciplinary actions. If so, please provide a description of the nature of the claim or settlement and the outcome.

Financial Information:

Please include the following information as it applies to the provider:

1. List the fiscal or calendar year end date: _____

2. Provide the facility's Tax Identification Number and a copy of the W-9 form or Internal Revenue Service (IRS) documentation to support this number.

   Tax Identification Number: _____

3. Please submit the facility's most recent schedule of charges for the specific services provided (FQHC, Rural, Health).

Financial Information: *(continued)*

4. Does the provider employ or pay for patient care services provided by physicians? ❑ Yes ❑ No

   a. If yes, please list the physicians and their license numbers.

Name and Degree	License Number	Specialty

   b. If no, but physician patient care is an integral part of the services provided, identify the physicians providing such services and describe how such services are being billed (please attach a separate sheet, if necessary).

Name and Degree	License Number	Specialty

5. Does the provider employ Certified Registered Nurse Anesthetists (CRNA), Certified Registered Nurse Practitioners (CRNP), or Physician Assistance? ❑ Yes ❑ No

   a. If yes, please provide their name, degree, and license number.

Name and Degree	License Number

6. Submit a description of procedures in place to assess patient/customer satisfaction and provide a summary of the last assessment.

7. Please submit a copy of the Patients' Bill of Rights.

Financial Information: *(continued)*

8. What are the current Electronic Data Interchange (EDI) capabilities? Please list methods.

9. Does the provider utilize the services of an outside billing company/vendor? ❑ Yes ❑ No

   If yes, please list name, address, telephone number, and contact person.

Related Organization Information:

1. a. Is the facility related to any other health care provider? ❑ Yes ❑ No

   b. If yes, please describe.

2. a. Do the facility and the related provider share any services (for example, laboratory and x-ray services)?

   ❑ Yes ❑ No

   b. If yes, please describe.

   c. Are the services of the facility integrated with corresponding inpatient services in any way? ❑ Yes ❑ No

   d. If yes, please describe.

   e. Are the facility's patients who need other levels of care ordinarily referred to the related provider?

   ❑ Yes ❑ No

   f. If yes, please describe.

Additional Information:

You may include any other information that you believe would assist us in reviewing your application, including additional site locations if applicable.

_____

_____

_____

_____

_____

_____

Attestation:

I attest to the completeness and accuracy of this information provided to Capital BlueCross on the Capital BlueCross Member Provider Application and all other information submitted.

Application Completed By:

_____ _____

Name Title

_____ ( ) -

Signature Phone Number ext.

_____

Date

REQUIREMENTS TO CONTRACTING

Enrollment with Navinet to be completed upon participation to access the latest fee schedules, forms, policies, and other communications. You will need to keep your e-mail address current, so we can send you important notices.

Capital BlueCross uses electronic payments as our preferred method of payment for provider reimbursement. Providers are required to sign up for EFT to receive payment for Capital BlueCross members.

You will receive a welcome letter once you become a contracted provider.

Attachment #1:

Provider Name: _____

Affiliated Services: Please list services and locations that represent:

A. Off-site service locations owned by and operated as a part of the provider/facility.

B. Service entities operating as a wholly owned subsidiary of the provider.

C. Service entity affiliated with the provider operating as a separate corporation.

Name: _____

Address: _____ County: _____

Service: _____

Phone: ( ) - ext. Fax: ( ) - ext. Website: _____

Contact Person (Name and Title): _____

Office Hours: _____ Email Address: _____

Code That Best Describes Relationship: ❑ A ❑ B ❑ C

Languages Spoken: _____ Handicap Accessibility: ❑ Yes ❑ No

Attachment #1: *(continued)*

Name: _____

Address: _____ County: _____

Service: _____

Phone: (____) ____ - ____ ext. ____ Fax: (____) ____ - ____ ext. ____ Website: _____

Contact Person (Name and Title): _____

Office Hours: _____ Email Address: _____

Code That Best Describes Relationship: ❑ A ❑ B ❑ C

Languages Spoken: _____ Handicap Accessibility: ❑ Yes ❑ No

Name: _____

Address: _____ County: _____

Service: _____

Phone: (____) ____ - ____ ext. ____ Fax: (____) ____ - ____ ext. ____ Website: _____

Contact Person (Name and Title): _____

Office Hours: _____ Email Address: _____

Code That Best Describes Relationship: ❑ A ❑ B ❑ C

Languages Spoken: _____ Handicap Accessibility: ❑ Yes ❑ No

Contracting Check List:

Before returning the application to Capital BlueCross, have you completed the following?:

- ➢ Responded to all questions asked on the application
- ➢ Included a completed Provider Assessment Survey
- ➢ Included Attachment 1 to the Provider Application
- ➢ Provided the following on the pages indicated (as applicable):
  - ❑ List of owners/major stockholders (page 3)
  - ❑ Copy of bylaws and incorporation papers (page 3)
  - ❑ Fictitious name filing (page 3)
  - ❑ List of Board of Trustees/Board of Directors (page 3)
  - ❑ Corporate organizational chart (page 3)
  - *❑ Hospice—for inpatient hospice care, please list providers used for general inpatient care and submit a sample contract used for this care (page 3)
  - ❑ Department of Health license or other state licenses, as applicable (page 5)
  - ❑ Copy of the most recent state survey results (page 5)
  - ❑ Copy of accreditation letters certifying the dates of accreditation or application for accreditation (page 5)
  - ❑ CMS Letter of Notification – Medicare Participation (page 5)
  - ❑ Medical Assistance provider number notification (page 5)
  - ❑ General liability, property, and professional liability insurance face sheets (page 6)
  - ❑ Copy of W-9 form or equivalent IRS documentation (page 6)
  - ❑ Schedule of charges (page 6)
  - ❑ List of physicians employed by/providing services to the facility (page 7)
  - ❑ Patient/Customer satisfaction survey (page 7)
  - ❑ Patient's Bill of Rights (page 7)