Capital Blue Cross
Facility/Ancillary provider application

Note: Anything marked with an asterisk (*) is a required section.

*Section 1—Provider information	
*Date:	
*Legal entity name:	
*Provider DBA name:	
*Provider type 2 NPI:	*Provider tax ID number:
*Primary taxonomy code:	Additional taxonomy codes:
Medicare provider number:	SAMHSA cert number:

*Section 2—Contacts	
*Business office manager:	Administrator/CEO:
*First name:	First name:
*Last name:	Last name:
*Title:	Title:
*Phone: ( ) . ext.	Phone: ( ) . ext.
Fax: ( ) . ext.	Fax: ( ) . ext.
*Email:	Email:
CFO:	Value-based program contact:
First name:	First name:
Last name:	Last name:
Title:	Title:
Phone: ( ) . ext.	Phone: ( ) . ext.
Fax: ( ) . ext.	Fax: ( ) . ext.
Email:	Email:
QA coordinator:	*Survey response contact—individual best suited to respond to satisfaction surveys:
First name:	*First name:
Last name:	*Last name:
Title:	*Title:
Phone: ( ) . ext.	*Phone: ( ) . ext.
Fax: ( ) . ext.	Fax: ( ) . ext.
Email:	*Email:
*Payment contact:	UR coordinator:
*First name:	First name:
*Last name:	Last name:
*Title:	Title:
*Phone: ( ) . ext.	Phone: ( ) . ext.
Fax: ( ) . ext.	Fax: ( ) . ext.
*Email:	Email:

*Section 3—Provider type

☐ Acute care hospital	☐ Agency-autism services	Outpatient freestanding:	Outpatient freestanding:
☐ Ambulance	☐ Outpatient substance abuse	☐ Ambulatory surgical center	☐ Radiation therapy center
☐ DME supplier	☐ Partial psychiatric facility-OP	☐ Birthing center	☐ Rehabilitation hospital
☐ Home health agency	☐ Substance abuse detox-IP	☐ Comprehensive OP rehab facilities	☐ Rehabilitation unit
☐ Hospice-see checklist	☐ Substance abuse rehabilitation-IP	☐ Diagnostic screening center	☐ Renal dialysis center
☐ Infusion therapy	☐ Residential treatment-IP	☐ Hemophilia center	☐ Retail center
☐ Laboratory	☐ Psychiatric facility-OP	☐ Hospital based PCP clinic	☐ Urgent care center–complete provider data form located under other professional provider types section
☐ Long term acute care hospital	☐ Psychiatric hospital-IP	☐ Physical rehab-OP	☐ Other-please specify:
☐ Prosthetics and orthotics	☐ Psychiatric unit		
☐ Skilled nursing facility			
☐ State/Federal owned hospital			
☐ Subacute unit-SNF			
☐ Veterans affairs hospital			

***Description of services:** *Briefly describe the program and/or services offered by the provider (*Behavioral health providers—include all formal licensed program descriptions for the services requested on the contract).

*Section 4—Addresses

***Corporate location:** *(This is where we will mail your fully executed agreement and certain legal notices.)*		
*Street/PO Box:		*County:
*City:	*State:	*ZIP Code:
*Phone number: ( ) . ext.	Fax number: ( ) . ext.	
*Email:		
*Please list those who are authorized to sign contracts on behalf of the facility:		
*Signatory contact name:	*Title:	
*Phone number: ( ) . ext.	Fax number: ( ) . ext.	
*Contract contact name:	*Title:	
*Contract contact phone: ( ) . ext.	Contract contact fax number: ( ) . ext.	
***Primary site location:**		
*Street/PO Box:		*County:
*City:	*State:	*ZIP Code:
*Phone number: ( ) . ext.	Fax number: ( ) . ext.	
*Email:	*Provider website address:	
*Languages spoken:	*Handicap accessibility: ☐ Yes ☐ No	
*Date of operation/scheduled date of opening:		
*Bed count (required for Acute Care hospitals and Skilled Nursing Facilities only):		

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
*Primary office hours							

***Behavioral health providers only:** based on your provider type, please check the populations served and type of services offered at the primary site location above:				
Population(s) served (select at least one age group below)				
☐ Seniors/Geriatrics > 65	☐ Adults 18-64	☐ Adolescents	☐ Other children 6-12	☐ Young children < 5

Provider type	**Type of services (select service based on provider type)**	
Substance abuse-OP	☐	SA partial hospitalization
	☐	SA IOP
	☐	SA OP treatment
	☐	Medication-assisted treatment
	☐	Opioid treatment program
Psychiatric hospital	☐	IP psych services
Substance abuse rehab-IP	☐	SU IP detox
Substance abuse detox-IP	☐	SU IP rehab/resident treatment
Psychiatric facility-OP	☐	Psych OP treatment
	☐	Psych IOP
Partial psych facility-OP	☐	Partial hospitalization services
Psychiatric unit	☐	IP psych services
Residential treatment-IP	☐	Psych IP residential treatment
Agency-autism services only	☐	ABA services

Additional office location (affiliated with NPI and tax ID listed above):		
*Street:		*County:
*City:	*State:	*ZIP Code:
*Phone number: ( ) . ext.	Fax number: ( ) . ext.	
*Email:	*Provider website address:	
*Languages spoken:	*Handicap accessibility: ☐ Yes ☐ No	
*Date of operation/scheduled date of opening:		

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
*Additional location office hours							

***Behavioral health providers only:** based on your provider type, please check the populations served and the type of services offered at the additional office location above:				
Population(s) served (select at least one age group below).				
☐ Seniors/Geriatrics > 65	☐ Adults 18—64	☐ Adolescents	☐ Other children 6—12	☐ Young children < 5

Provider type	**Type of services (select service based on provider type).**	
Substance abuse-OP	☐	SA partial hospitalization
	☐	SA IOP
	☐	SA OP treatment
	☐	Medication-assisted treatment
	☐	Opioid treatment program
Psychiatric hospital	☐	IP psych services
Substance abuse rehab-IP	☐	SU IP detox
Substance abuse detox-IP	☐	SU IP rehab/resident treatment
Psychiatric facility-OP	☐	Psych OP treatment
	☐	Psych IOP
Partial psych facility-OP	☐	Partial hospitalization services
Psychiatric unit	☐	IP psych services
Residential treatment-IP	☐	Psych IP residential treatment
Agency-autism services only	☐	ABA services

*Correspondence: *(Please complete the correspondence/remit/medical records addresses below if it differs from the primary location.)*		
*Street/PO Box:		*County:
*City:	*State:	*ZIP Code:
*Phone number: ( ) . ext.	Fax number: ( ) . ext.	
Email:		
***Remit:** *(This is where you want to receive payment related correspondences.)*		
*Street/PO Box:		*County:
*City:	*State:	*ZIP Code:
*Phone number: ( ) . ext.	Fax number: ( ) . ext.	
Email:		
Billing: *(business office/billing office)*		
Street/PO Box:		County:
City:	State:	ZIP Code:
Phone number: ( ) . ext.	Fax number: ( ) . ext.	
Email:		
***Medical records:**		
*Medical records contact person:		
*Title:		
*Street/PO Box:		*County:
*City:	*State:	*ZIP Code:
*Phone number: ( ) . ext.	Fax number: ( ) . ext.	
*Email:		

Section 5—Certification/Accreditation: *Please respond to the following and include those items applicable to your organization.

1. 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 healthcare 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.

2. Please explain if the provider is certified as a provider in the Medicare and Medicaid programs:

   Medicare ☐ Yes ☐ No

   Medicaid ☐ Yes ☐ No

   a. If yes for Medicare, please provide a copy of the CMS certification determination letter and advise the following:

      Name of Medicare intermediary:
      1.

      Effective date of Medicare participation:

   b. If yes for Medicaid, please provide a copy of the certificate of certification and the following:

      Effective date of Medicaid participation:

3. 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 Medicaid 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).

4. Has the facility been excluded or debarred from a federal health benefit program?

   ☐ Yes ☐ No

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

   ☐ Yes ☐ No

   If yes, please explain:

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

   ☐ Yes ☐ No

   If yes, please explain:

6. 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 or debarred from a federal health benefit program?

   ☐ Yes ☐ No

   If no, please explain:

7. 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 or debarred from a federal health benefit program?

   ☐ Yes ☐ No

   If no, please explain:

8. 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 Blue Cross.

9. Has the provider had any revocation or suspension of license to provide healthcare by any state licensing authority?

   ☐ Yes ☐ No

10. Within the last five (5) years, have there been or are there 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.

*Section 6—Financial information:

1. Does the provider employ or pay for patient care services provided by physicians or allied health professionals (i.e. certified registered nurse anesthetists (CRNA), certified registered nurse practitioners (CRNP), certified nurse midwives (CNM) or physician assistants? ☐ Yes ☐ No

   a. If yes, please list their name(s), degree(s), license number(s) and specialty(ies) (please attach a separate sheet, if necessary).

Name and degree	License number	Specialty

   b. If no, but physician patient care is an integral part of the services provided, please list the name(s), degree(s), license number(s) and specialty(ies) of those providing such services and describe how such services are being billed (please attach a separate sheet, if necessary).

Name and degree	License number	Specialty

*Section 7—Related organization information:

1. Is the facility related to any other healthcare provider? ☐ Yes ☐ No

   If yes, please describe.

2. a. Does 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?

   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.

*Section 8—Attestation

I attest to the completeness and accuracy of this information provided to Capital Blue Cross on the provider application and all other information submitted and affirmatively state that I am authorized by the Facility/Ancillary provider to do so.

Application completed by:

Name	Title	Date
	( ) .	
Signature	Phone number	Ext.

Requirements to contracting

Upon participation approval, you will be enrolled in all applicable Capital Blue Cross programs.

Enrollment with Availity 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 Blue Cross 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 Blue Cross members.

*Section 9—Provider check list:

Before returning the application to Capital Blue Cross, please ensure you have completed and/or attached a copy of the following:

- ☐ Provider application fully completed, signed and dated.
- ☐ Accreditation letters certifying the dates of accreditation or application for accreditation.
- ☐ Behavioral health providers—include all formal licensed program descriptions for the services requested on the contract.
- ☐ CMS letter of notification—Medicare participation.
- ☐ All providers offering OTP must provide SAMHSA.
- ☐ Electronic Data Interchange (EDI) fully completed, signed and dated.
- ☐ Electronic Funds Transfer (EFT) fully completed, signed and dated.
- ☐ Hospice—for inpatient hospice care, list of providers used for general inpatient care and submit a sample contract used for this care.
- ☐ List of physicians and/or employed by/providing services to the facility.
- ☐ Most recent state survey results.
- ☐ Provider assessment survey.
- ☐ 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.).
- ☐ Third party authorization form (required if utilizing the services of an outside billing company/vendor).
- ☐ W-9 fully completed, signed and dated.

Items that are not required, but may be requested at a later date

- ☐ General liability, property, and professional liability insurance face sheets.
- ☐ Patient/Customer satisfaction survey.
- ☐ Patient's bill of rights.