Provider Credentialing & Data Management Webinar

For the listening benefit of webinar attendees, we have muted all lines and will be starting our presentation shortly.

- This helps prevent background noise (e.g., unmuted phones or phones put on hold) during the webinar.
- This also means we are unable to hear you during the webinar.
- Please submit your questions directly through the webinar platform only.

How to submit questions:

- Open the chat feature at the bottom of your screen to type your question related to today's training webinar.
- In the "Send to" field, select "Hosts and Panelists."
- Once your question is typed in, hit the "Send" button to send it to the presenter.
- We will address submitted questions at the end of the webinar.

PROVIDER CREDENTIALING & DATA MANAGEMENT

Melonie Martin
Provider Relations

September 2021

Louisiana

Joining Our Networks

There are two options for obtaining a Blue Cross provider record:

1. You may request network participation as a **participating provider**.
2. You may request just a provider record as a **non-participating provider** for the purpose of filing claims.

Participating vs. Non-participating Providers

Participating Provider

- Provider has entered into a contractual agreement with Blue Cross to provide covered services to our members.
- Payments are based on the provider's schedule of allowable charges.
- Provider may bill the member for any deductible, coinsurance, copayment and/or non-covered service. Provider agrees not to collect any amount over the allowable charge from the member.
- Payment goes directly to the participating provider.
- Participating providers see increased Blue Cross patient volume since members receive higher benefits when using network providers.
- Only participating providers are listed in our online provider directory featured on our corporate website (**www.BCBSLA.com**).

Participating vs. Non-participating Providers

Non-participating Provider

- Provider has chosen not to sign a network agreement with Blue Cross.
- We establish a non-participating rate for covered services rendered by non-participating providers.
- The provider may balance bill the member for all amounts not paid by Blue Cross.
- In most situations, Blue Cross payments for claims to a non-participating provider are sent directly to the member.
- Some members may have no benefits for services provided by non-participating providers without obtaining prior approval.
- Non-participating providers are **not** listed in our online provider directory.

Credentialing Overview for Participating Providers

- Since 1996, we have been dedicated to fully credentialing providers who apply for network participation.
- Our credentialing program is accredited by the Utilization Review Accreditation Commission (URAC).
- To participate in our networks, providers must meet certain criteria as regulated by our accreditation body and the Blue Cross and Blue Shield Association.
- We credential professional and facility providers.
- Included on the next slides are brief overviews of our processes, criteria and requirements for providers to request network participation.

Credentialing Process

- The credentialing process can take up to 90 days after all required information is received.
- Providers will remain non-participating in our networks until a signed agreement is received by our contracting department.
- The committee approves credentialing twice per month.
- Network providers are recredentialed every three years from their last credentialing acceptance date.

After 90 days, you may inquire about your credentialing status by contacting our Provider Credentialing & Data Management (PCDM) Department at **pcdmstatus@bcbsla.com**.

Credentialing Committee

The Credentialing Committee:

- Has the final authority to make decisions regarding provider participation.
- Provides guidance and suggestions for the credentialing process.
- Is made up of a diverse group of network providers from across the state with no other management role at Blue Cross.
- Includes multiple Blue Cross employees from Medical Management, Provider Credentialing & Data Management and Provider Contracting.

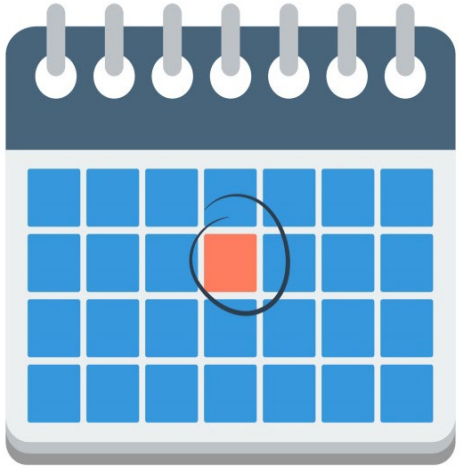
Providers may appeal committee decisions using our *Appeals and Terminations Guidelines*, available online at **www.BCBSLA.com/providers** >Provider Networks >Join Our Networks.

Effective Dates

For participating providers:

- We cannot retroactively allow network participation prior to a provider's credentialing date. Our accrediting organization strictly prohibits it.

- The effective date of a provider's network participation will be preceded by the following:
  - For delegated providers, approval of the Credentialing Delegation spreadsheet by our Medical Director;
  - **And** the execution of your network agreement.



- Louisiana has expanded its law allowing additional provider types to request that Blue Cross reimburse their claims as if they are a network physician during the credentialing process. That special non-participating effective date can be retroactive up to two months from the date we received the application and request, based on the effective date of hospital privileges.

For non-participating providers:

- Presently, we allow non-participating effective dates up to two years back for providers who want a provider record only for filing claims.

Effective Dates

For new providers who are not credentialed, their earliest effective date will be:

- If you submitted a reimbursement during credentialing request, then it is the date when the hospital medical staff privileges become active; **OR**

- If you did not submit a reimbursement during credentialing request, then it is the approved date by the Credentialing Committee.

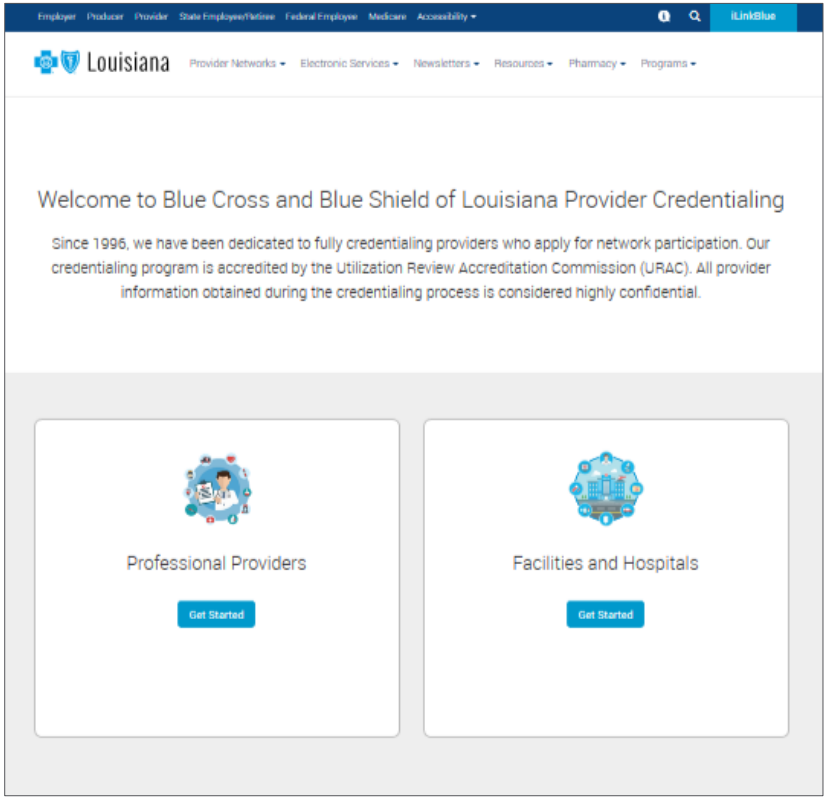
For providers who are already credentialed, their earliest effective date will be:

- If the requested effective date on the Provider Update Request Form (Existing Providers Joining a New Provider Group) is within 90 days of the calendar date, then it will be that date, but not before the group's effective date.

- If the requested effective date on the Provider Update Request Form (Existing Providers Joining a New Provider Group) is greater than 90 days of the calendar date, then it will be 90 days from the day the information was received, but not before the group's effective date.

Credentialing Webpage

To join our networks, you must complete and submit documentation to start the credentialing process or to obtain a provider record.

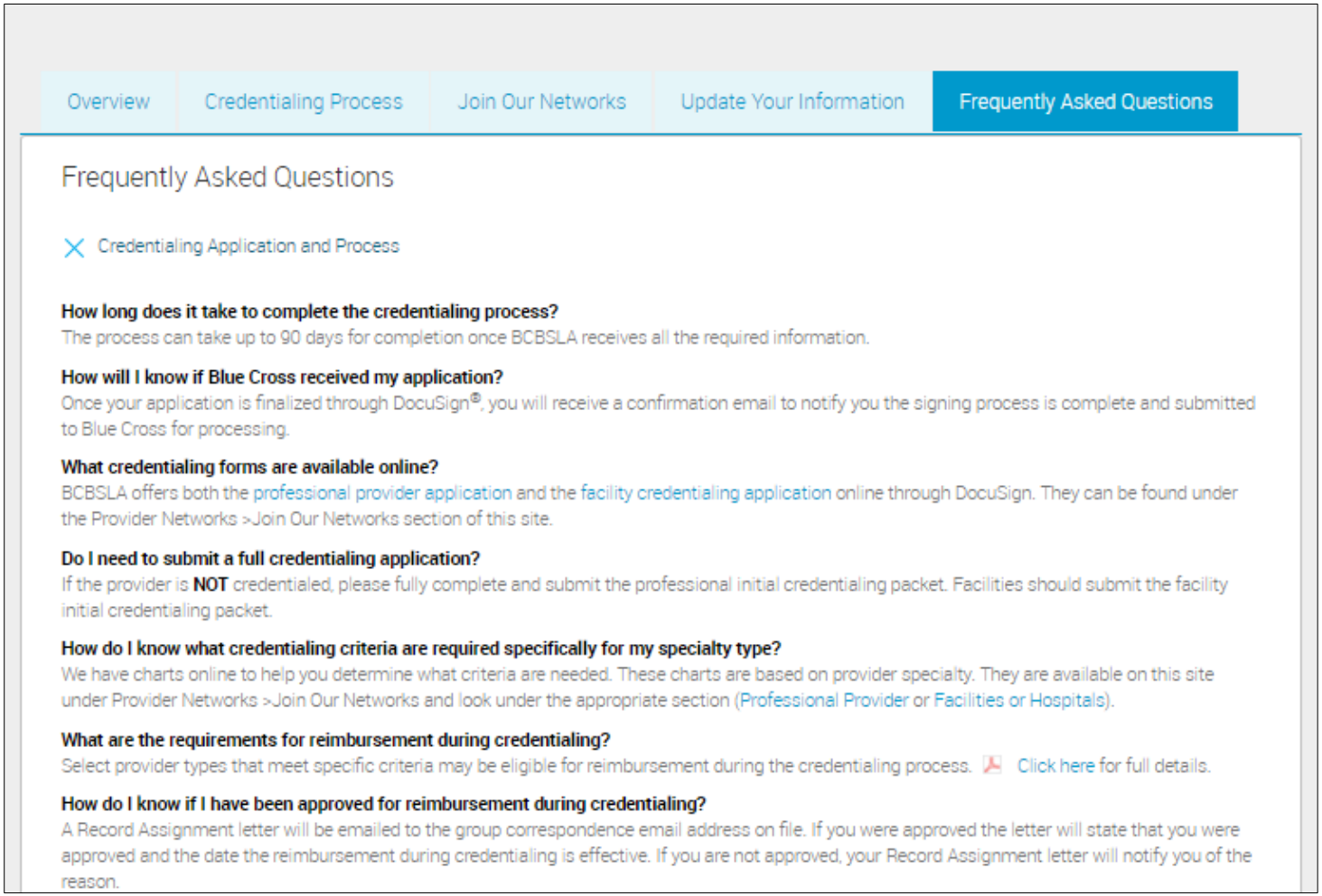


Go to the **Join Our Networks** page then, select **Professional Providers** or **Facilities and Hospitals** to find:

- Credentialing packets
- Quick links to the Provider Update Request Form
- Credentialing criteria for professional, facility and hospital-based providers

www.BCBSLA.com/providers >Provider Networks >Join Our Networks

Frequently Asked Questions



www.BCBSLA.com/providers >Provider Networks >Join Our Networks >Professional Providers/Facilities and Hospitals >Frequently Asked Questions

Credentialing Criteria for Professional Providers

The following professional provider types must meet certain criteria to participate in our networks:

- Acupuncturists
- Applied Behavioral Analysts (ABA)
- Audiologist
- Certified Nurse Midwife (CNM)
- Certified Registered Nurse Anesthetist (CRNA)
- Doctor of Chiropractic (DC)
- Doctor of Osteopathic (DO)
- Doctor of Medicine (MD)
- Doctor of Podiatric Medicine (DPM)
- Doctor of Dental Surgery (DDS)
- Doctor of Medicine in Dentistry (DMD)
- Hearing Aid Dealer
- Licensed Addictive Counselor (LAC)
- Licensed Professional Counselor (LPC)
- Licensed Clinical Social Worker (LCSW)
- Nurse Practitioner (NP)
- Occupational Therapist (OT)
- Optometrist (OD)
- Physician Assistant (PA)
- Psychologist (PhD)
- Physical Therapist (PT)
- Registered Dietician & Nutritionist (RD)
- Speech-Language Pathologist & Audiologist (SLP)

View the *Credentialing Criteria* for these professional provider types at **www.BCBSLA.com/providers** >Provider Networks >Join Our Networks >Professional Providers >Credentialing Process.

Digitally Submitting Applications & Forms to Blue Cross with DocuSign®

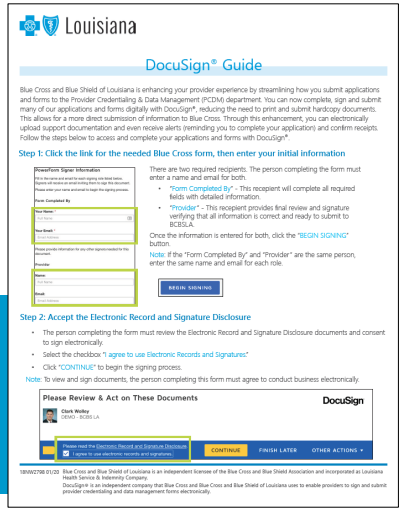
Blue Cross and Blue Shield of Louisiana is excited to announce that we are enhancing your provider experience by streamlining how you can submit applications and forms to the PCDM Department. You can now complete, sign and submit many of our applications and forms digitally with **DocuSign**.

This enhancement will help streamline your submissions by reducing the need to print and submit hardcopy documents, allowing for a more direct submission of information to Blue Cross. Through this enhancement, you will be able to electronically upload support documentation and even receive alerts reminding you to complete your application and confirm receipt.

What is DocuSign?

As an innovator in e-signature technology, DocuSign helps organizations connect and automate how various documents are prepared, signed and managed.

To help with this transition, we created a *DocuSign® Guide* that is available online at **www.BCBSLA.com/providers >Join Our Networks**.


Louisiana

DocuSign® Guide

Blue Cross and Blue Shield of Louisiana is enhancing your provider experience by streamlining how you submit applications and forms to the Provider Credentialing & Data Management (PCDM) department. You can now complete, sign and submit many of our applications and forms digitally with DocuSign®, reducing the need to print and submit hardcopy documents. This allows for a more direct submission of information to Blue Cross. Through this enhancement, you can electronically upload support documentation and even receive alerts (reminding you to complete your applications) and confirm receipts. Follow the steps below to access and complete your applications and forms with DocuSign®.

Step 1: Click the link for the needed Blue Cross form, then enter your initial information

There are two required recipients. The person completing the form must enter a name and email for both.

- "Form Completed By" - This recipient will complete all required fields with detailed information.
- "Provider" - This recipient provides final review and signature verifying that all information is correct and ready to submit to BCBSLA.

Once the information is entered for both, click the "BEGIN SIGNING" button.

Note: If the "Form Completed By" and "Provider" are the same person, enter the same name and email for each role.

Step 2: Accept the Electronic Record and Signature Disclosure

- The person completing the form must review the Electronic Record and Signature Disclosure documents and consent to sign electronically.
- Select the checkbox "I agree to use Electronic Records and Signatures."
- Click "CONTINUE" to begin the signing process.

Note: To view and sign documents, the person completing this form must agree to conduct business electronically.

Please Review & Act on These Documents

DocuSign

CONTINUE FINISH LATER OTHER ACTIONS

Easily complete packets & forms with DocuSign

Credentialing packets:

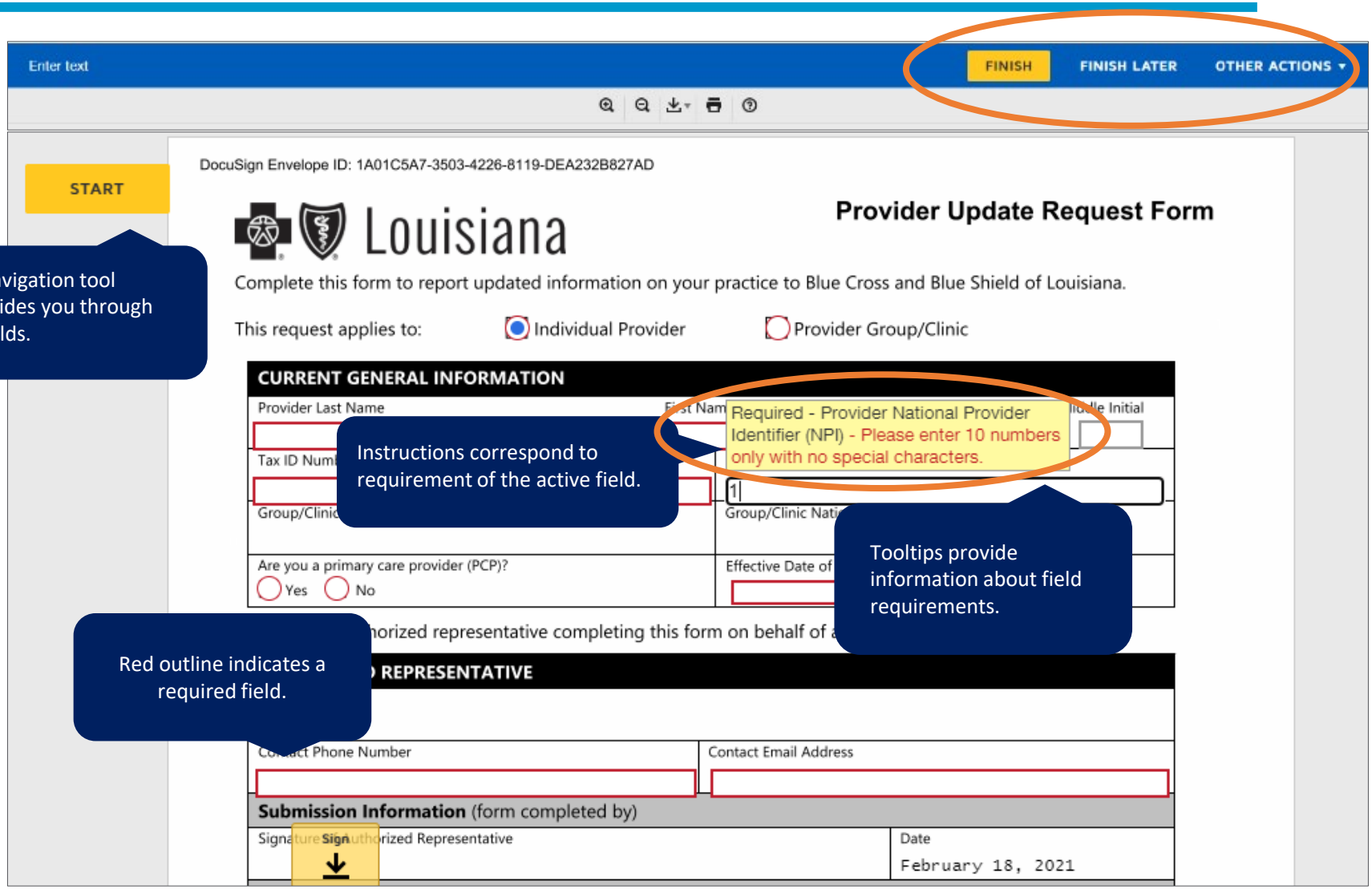
- Professional (initial)
- Facility (initial)

Forms:

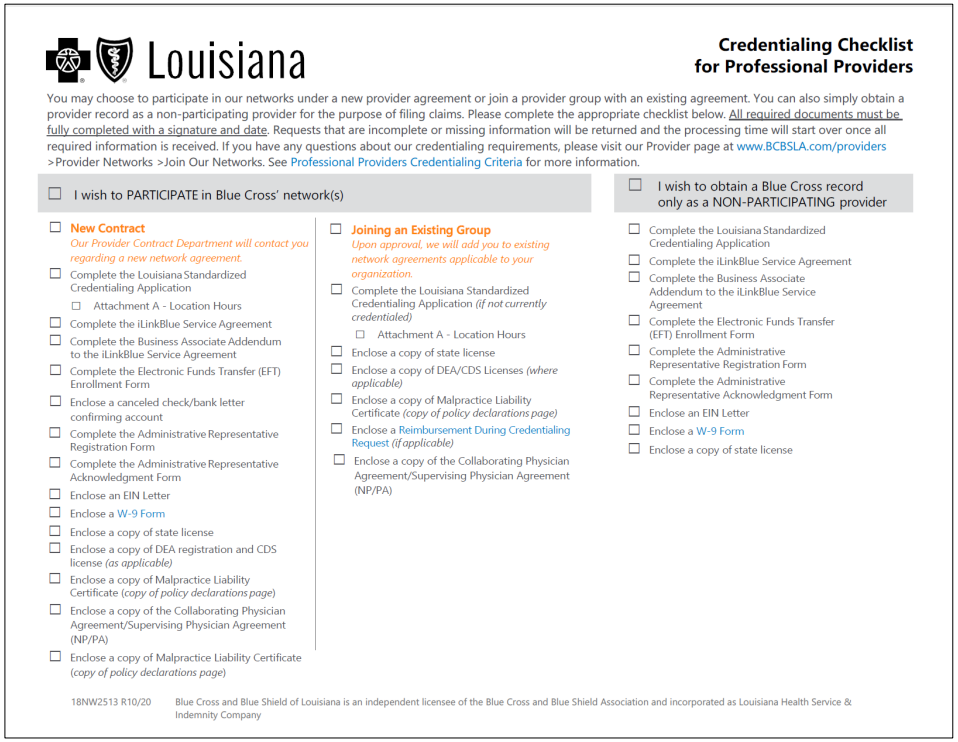
- **Provider Update Request Form** – to update information such as:
  - Demographic Information – for updating contact information
  - Existing Providers Joining a New Provider Group – if you are joining an existing provider group or clinic or adding new providers to your group
  - Add Practice Location – to add a practice location(s)
  - Remove Practice Location – to remove a practice location(s)
  - Tax Identification Number (TIN) Change – to change your Tax ID number
  - Terminate Network Participation – to terminate existing network participation or an entire provider record
  - EFT Term/Change Request – to change your electronic funds transfer (EFT) information or to cancel receiving payments via this method
- **EFT Enrollment Form** – to begin receiving payments via electronic funds transfer (EFT)

After submitting your documents through DocuSign, please do not send via email.

Easily complete forms with DocuSign



Required Supporting Documentation for Professional Providers



Louisiana

Credentialing Checklist for Professional Providers

You may choose to participate in our networks under a new provider agreement or join a provider group with an existing agreement. You can also simply obtain a provider record as a non-participating provider for the purpose of filing claims. Please complete the appropriate checklist below. All required documents must be fully completed with a signature and date. Requests that are incomplete or missing information will be returned and the processing time will start over once all required information is received. If you have any questions about our credentialing requirements, please visit our Provider page at www.BCBSLA.com/providers >Provider Networks >Join Our Networks. See Professional Providers Credentialing Criteria for more information.

☐ I wish to PARTICIPATE in Blue Cross' network(s)

☐ **New Contract**
Our Provider Contract Department will contact you regarding a new network agreement.
- ☐ Complete the Louisiana Standardized Credentialing Application
  - ☐ Attachment A - Location Hours
- ☐ Complete the iLinkBlue Service Agreement
- ☐ Complete the Business Associate Addendum to the iLinkBlue Service Agreement
- ☐ Complete the Electronic Funds Transfer (EFT) Enrollment Form
- ☐ Enclose a canceled check/bank letter confirming account
- ☐ Complete the Administrative Representative Registration Form
- ☐ Complete the Administrative Representative Acknowledgment Form
- ☐ Enclose an EIN Letter
- ☐ Enclose a W-9 Form
- ☐ Enclose a copy of state license
- ☐ Enclose a copy of DEA registration and CDS license *(as applicable)*
- ☐ Enclose a copy of Malpractice Liability Certificate *(copy of policy declarations page)*
- ☐ Enclose a copy of the Collaborating Physician Agreement/Supervising Physician Agreement (NP/PA)
- ☐ Enclose a copy of Malpractice Liability Certificate *(copy of policy declarations page)*

☐ **Joining an Existing Group**
Upon approval, we will add you to existing network agreements applicable to your organization.
- ☐ Complete the Louisiana Standardized Credentialing Application *(if not currently credentialed)*
  - ☐ Attachment A - Location Hours
- ☐ Enclose a copy of state license
- ☐ Enclose a copy of DEA/CDS Licenses *(where applicable)*
- ☐ Enclose a copy of Malpractice Liability Certificate *(copy of policy declarations page)*
- ☐ Enclose a Reimbursement During Credentialing Request *(if applicable)*
- ☐ Enclose a copy of the Collaborating Physician Agreement/Supervising Physician Agreement (NP/PA)

☐ I wish to obtain a Blue Cross record only as a NON-PARTICIPATING provider
- ☐ Complete the Louisiana Standardized Credentialing Application
- ☐ Complete the iLinkBlue Service Agreement
- ☐ Complete the Business Associate Addendum to the iLinkBlue Service Agreement
- ☐ Complete the Electronic Funds Transfer (EFT) Enrollment Form
- ☐ Complete the Administrative Representative Registration Form
- ☐ Complete the Administrative Representative Acknowledgment Form
- ☐ Enclose an EIN Letter
- ☐ Enclose a W-9 Form
- ☐ Enclose a copy of state license

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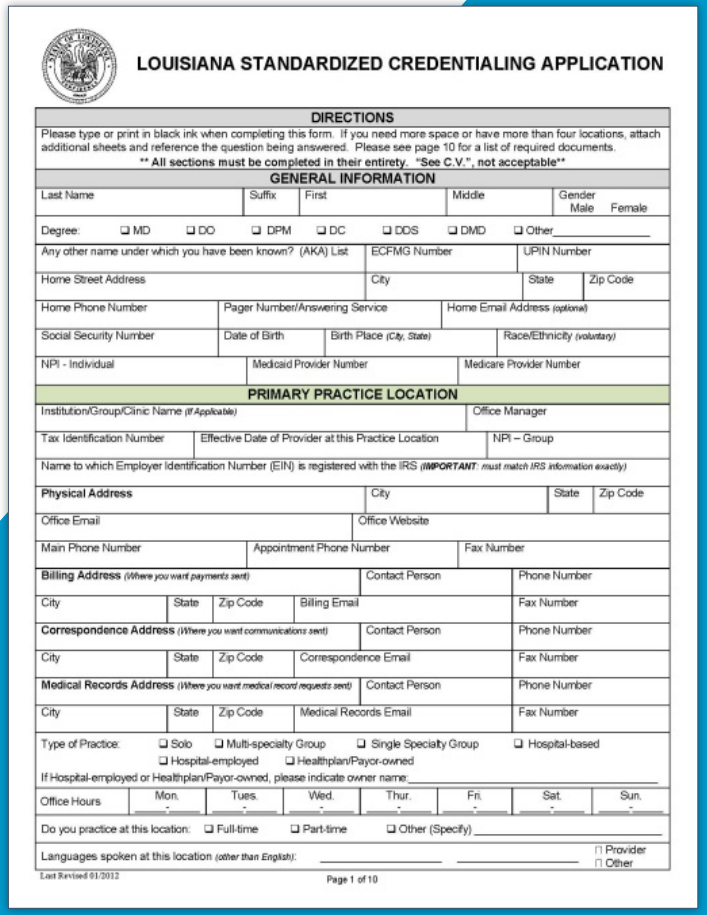
- The Professional (initial) credentialing packet includes a checklist of all required documents.
- To **join our networks through a new contract**, or **joining an existing group**, complete the checklist under "I wish to PARTICIPATE in Blue Cross' network(s)."
- If you **want a provider record only for filing claims**, complete the checklist under "I wish to obtain a Blue Cross record only as a NON-PARTICIPATING provider."

- **You must complete the applicable checklist and submit all the indicated documents.**
- **Credentialing packets with incomplete, missing information or submitted incorrectly will be returned.**

Recredentialing Application

Blue Cross uses the Louisiana Standardized Credentialing Application (LSCA) for both credentialing and recredentialing applications.

Find our credentialing links at **www.BCBSLA.com/providers** >Provider Networks >Join Our Networks.



LOUISIANA STANDARDIZED CREDENTIALING APPLICATION

DIRECTIONS

Please type or print in black ink when completing this form. If you need more space or have more than four locations, attach additional sheets and reference the question being answered. Please see page 10 for a list of required documents.

**** All sections must be completed in their entirety. "See C.V.", not acceptable****

GENERAL INFORMATION

Last Name | Suffix | First | Middle | Gender Male Female

Degree: ❑ MD ❑ DO ❑ DPM ❑ DC ❑ DDS ❑ DMD ❑ Other_____

Any other name under which you have been known? (AKA) List | ECFMG Number | UPIN Number

Home Street Address | City | State | Zip Code

Home Phone Number | Pager Number/Answering Service | Home Email Address *(optional)*

Social Security Number | Date of Birth | Birth Place *(City, State)* | Race/Ethnicity *(voluntary)*

NPI - Individual | Medicaid Provider Number | Medicare Provider Number

PRIMARY PRACTICE LOCATION

Institution/Group/Clinic Name *(If Applicable)* | Office Manager

Tax Identification Number | Effective Date of Provider at this Practice Location | NPI – Group

Name to which Employer Identification Number (EIN) is registered with the IRS *(**IMPORTANT**: must match IRS information exactly)*

Physical Address | City | State | Zip Code

Office Email | Office Website

Main Phone Number | Appointment Phone Number | Fax Number

Billing Address *(Where you want payments sent)* | Contact Person | Phone Number

City | State | Zip Code | Billing Email | Fax Number

Correspondence Address *(Where you want communications sent)* | Contact Person | Phone Number

City | State | Zip Code | Correspondence Email | Fax Number

Medical Records Address *(Where you want medical record requests sent)* | Contact Person | Phone Number

City | State | Zip Code | Medical Records Email | Fax Number

Type of Practice: ❑ Solo ❑ Multi-specialty Group ❑ Single Specialty Group ❑ Hospital-based ❑ Hospital-employed ❑ Healthplan/Payor-owned

If Hospital-employed or Healthplan/Payor-owned, please indicate owner name:_____

Office Hours | Mon. - | Tues. - | Wed. - | Thur. - | Fri. - | Sat. - | Sun. -

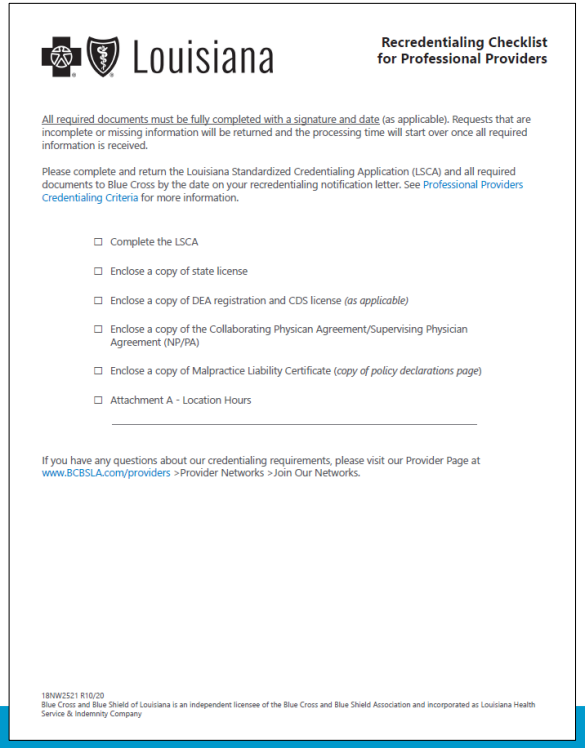
Do you practice at this location: ❑ Full-time ❑ Part-time ❑ Other (Specify) _____

Languages spoken at this location *(other than English)*: _____ _____ ❑ Provider ❑ Other

Last Revised 01/2012

Page 1 of 10

Required Recredentialing Supporting Documentation for Professional Providers



Louisiana

Recredentialing Checklist for Professional Providers

All required documents must be fully completed with a signature and date (as applicable). Requests that are incomplete or missing information will be returned and the processing time will start over once all required information is received.

Please complete and return the Louisiana Standardized Credentialing Application (LSCA) and all required documents to Blue Cross by the date on your recredentialing notification letter. See Professional Providers Credentialing Criteria for more information.

- ☐ Complete the LSCA
- ☐ Enclose a copy of state license
- ☐ Enclose a copy of DEA registration and CDS license *(as applicable)*
- ☐ Enclose a copy of the Collaborating Physican Agreement/Supervising Physician Agreement (NP/PA)
- ☐ Enclose a copy of Malpractice Liability Certificate (*copy of policy declarations page*)
- ☐ Attachment A - Location Hours

If you have any questions about our credentialing requirements, please visit our Provider Page at www.BCBSLA.com/providers >Provider Networks >Join Our Networks.

18NW2521 R10/20
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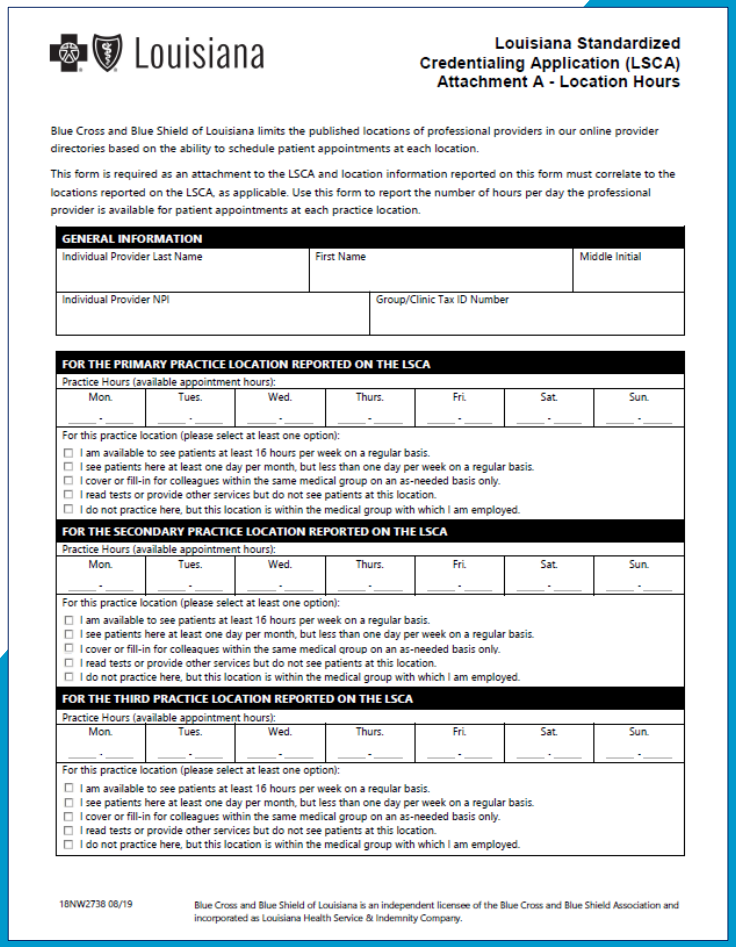
The Professional recredentialing packet includes a checklist of all required documents:

- Complete the LSCA.
- Enclose a copy of state license.
- Enclose a copy of DEA registration and CDS license *(as applicable)*.
- Enclose a copy of Malpractice Liability Certificate (*copy of policy declarations page*).
- Complete the LSCA Attachment A - Location Hours
- Enclose this completed checklist.
- **Enclose a copy of the Collaborative Physician Agreement/Supervising Physician Agreement for NPs and PAs.**

- **You must complete the applicable checklist and submit all the indicated documents.**
- **Recredentialing packets with incomplete, missing information or submitted incorrectly will be returned.**

LSCA Attachment A – Location Hours

- This new form is **required** as an attachment to the LSCA.
- Use this form to report the number of hours per day the professional provider is available for patient appointments at each practice location.
- Location information reported on this form must correlate to the locations reported on the LSCA, as applicable.
- We use the information from this form to determine if the provider meets the qualifications to be listed in our provider directory.



Louisiana

Louisiana Standardized Credentialing Application (LSCA) Attachment A - Location Hours

Blue Cross and Blue Shield of Louisiana limits the published locations of professional providers in our online provider directories based on the ability to schedule patient appointments at each location.

This form is required as an attachment to the LSCA and location information reported on this form must correlate to the locations reported on the LSCA, as applicable. Use this form to report the number of hours per day the professional provider is available for patient appointments at each practice location.

GENERAL INFORMATION

Individual Provider Last Name	First Name	Middle Initial

Individual Provider NPI	Group/Clinic Tax ID Number

FOR THE PRIMARY PRACTICE LOCATION REPORTED ON THE LSCA

Practice Hours (available appointment hours):

Mon.	Tues.	Wed.	Thurs.	Fri.	Sat.	Sun.
____ - ____	____ - ____	____ - ____	____ - ____	____ - ____	____ - ____	____ - ____

For this practice location (please select at least one option):

- ☐ I am available to see patients at least 16 hours per week on a regular basis.
- ☐ I see patients here at least one day per month, but less than one day per week on a regular basis.
- ☐ I cover or fill-in for colleagues within the same medical group on an as-needed basis only.
- ☐ I read tests or provide other services but do not see patients at this location.
- ☐ I do not practice here, but this location is within the medical group with which I am employed.

FOR THE SECONDARY PRACTICE LOCATION REPORTED ON THE LSCA

Practice Hours (available appointment hours):

Mon.	Tues.	Wed.	Thurs.	Fri.	Sat.	Sun.
____ - ____	____ - ____	____ - ____	____ - ____	____ - ____	____ - ____	____ - ____

For this practice location (please select at least one option):

- ☐ I am available to see patients at least 16 hours per week on a regular basis.
- ☐ I see patients here at least one day per month, but less than one day per week on a regular basis.
- ☐ I cover or fill-in for colleagues within the same medical group on an as-needed basis only.
- ☐ I read tests or provide other services but do not see patients at this location.
- ☐ I do not practice here, but this location is within the medical group with which I am employed.

FOR THE THIRD PRACTICE LOCATION REPORTED ON THE LSCA

Practice Hours (available appointment hours):

Mon.	Tues.	Wed.	Thurs.	Fri.	Sat.	Sun.
____ - ____	____ - ____	____ - ____	____ - ____	____ - ____	____ - ____	____ - ____

For this practice location (please select at least one option):

- ☐ I am available to see patients at least 16 hours per week on a regular basis.
- ☐ I see patients here at least one day per month, but less than one day per week on a regular basis.
- ☐ I cover or fill-in for colleagues within the same medical group on an as-needed basis only.
- ☐ I read tests or provide other services but do not see patients at this location.
- ☐ I do not practice here, but this location is within the medical group with which I am employed.

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In order to be listed in the directory, professional providers must be available to schedule patients' appointments a minimum of 16 hours per week at the location listed.

Reimbursement During Credentialing

Louisiana legislation was updated in 2021. House Bill 595 now allows additional healthcare provider types to request that Blue Cross reimburse their claims as if they are a network provider during the credentialing process. Claims for network providers are paid directly to the provider.

The following criteria must be met:

1. You must be applying for network participation to **join a provider group** that already has an executed group agreement on file with Blue Cross. This provision does not apply for solo practitioners.
2. You must be an **active member** on a network hospital medical staff. You must list this information in the hospital affiliations section on the appropriate credentialing application.
3. For nurse practitioners and physician assistants, you must submit the following with your initial application. Blue Cross will deny the request if the following is not submitted.
   - Nurse practitioners must submit a collaborative physician agreement.
   - Physician assistants must submit a supervising physician agreement.
4. Your **initial credentialing application** for network participation must include a written letter on letterhead and signed by the provider or authorized representative for the provider, requesting Blue Cross to reimburse you at the group contract rate and an agreement to hold our members harmless for payments above the allowable amount.

More information can be found on our guide at **www.bcbsla.com/providers** > Resources > Forms > How to Request Reimbursement During Credentialing.

Sample Reimbursement During Credentialing Request

Letterhead

{Date}

Dear Blue Cross and Blue Shield of Louisiana:

Please accept this written request to reimburse **{provider's name}** for services provided as a new provider at **{provider group name}** at our group contract rate and with in-network benefits.

{Provider group name} agrees that all contract provisions, including holding covered members harmless for charges beyond the Blue Cross allowable amount and the member's cost share amount (deductible, coinsurance and/or copayment, as applicable) will apply to the new provider.

{Original signature of the provider/authorized representative for the provider}

Typed signatures will NOT be accepted

Credentialing Criteria for Facility Providers

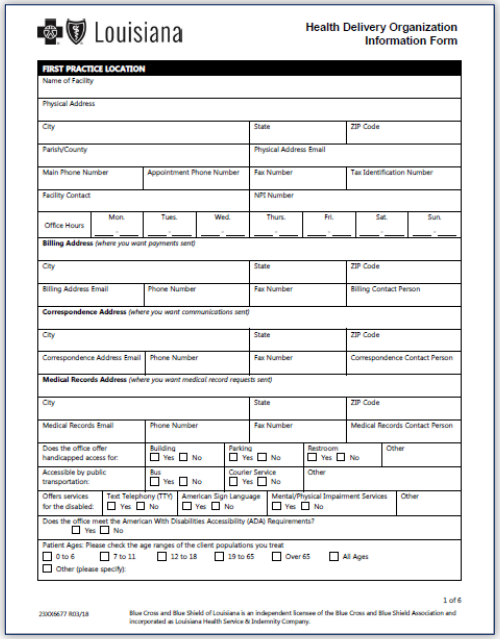
The following facility provider types must meet certain criteria requirements to participate in our networks:

- Ambulance Service
- Ambulatory Surgical Center
- Birthing Centers
- Cardiac Cath Lab (Outpatient)
- Diagnostic Services
- Dialysis Facility
- DME Supplier
- Emergency Medicine Physician Groups
- Home Health Agency
- Home Infusion
- Hospice
- Hospitals
- IOP/PHP Psych/CDU
- Laboratory
- Lithotripsy/Orthotripsy
- Nursing Home
- Radiation Center
- Residential Treatment
- Retail Health Clinic
- Skilled Nursing Facility
- Sleep Lab/Center
- Specialty Pharmacy
- Urgent Care Clinic

View the *Credentialing Criteria* for these facility provider types at **www.BCBSLA.com/providers** >Provider Networks >Join Our Networks >Facilities and Hospitals >Credentialing Process.

Required Credentialing Applications for Facility Providers

Providers starting the credentialing process should use our **Health Delivery Organization Information Form**.



Louisiana

Health Delivery Organization Information Form

FIRST PRACTICE LOCATION

Name of Facility

Physical Address

City | State | ZIP Code

Parish/County | Physical Address Email

Main Phone Number | Appointment Phone Number | Fax Number | Tax Identification Number

Facility Contact | NPI Number

Office Hours: Mon. ___ - ___ | Tues. ___ - ___ | Wed. ___ - ___ | Thurs. ___ - ___ | Fri. ___ - ___ | Sat. ___ - ___ | Sun. ___ - ___

Billing Address *(where you want payments sent)*

City | State | ZIP Code

Billing Address Email | Phone Number | Fax Number | Billing Contact Person

Correspondence Address *(where you want communications sent)*

City | State | ZIP Code

Correspondence Address Email | Phone Number | Fax Number | Correspondence Contact Person

Medical Records Address *(where you want medical record requests sent)*

City | State | ZIP Code

Medical Records Email | Phone Number | Fax Number | Medical Records Contact Person

Does the office offer handicapped access for: Building ☐ Yes ☐ No | Parking ☐ Yes ☐ No | Restroom ☐ Yes ☐ No | Other

Accessible by public transportation: Bus ☐ Yes ☐ No | Courier Service ☐ Yes ☐ No | Other

Offers services for the disabled: Text Telephony (TTY) ☐ Yes ☐ No | American Sign Language ☐ Yes ☐ No | Mental/Physical Impairment Services ☐ Yes ☐ No | Other

Does the office meet the American With Disabilities Accessibility (ADA) Requirements? ☐ Yes ☐ No

Patient Ages: Please check the age ranges of the client populations you treat
☐ 0 to 6 ☐ 7 to 11 ☐ 12 to 18 ☐ 19 to 65 ☐ Over 65 ☐ All Ages
☐ Other (please specify):

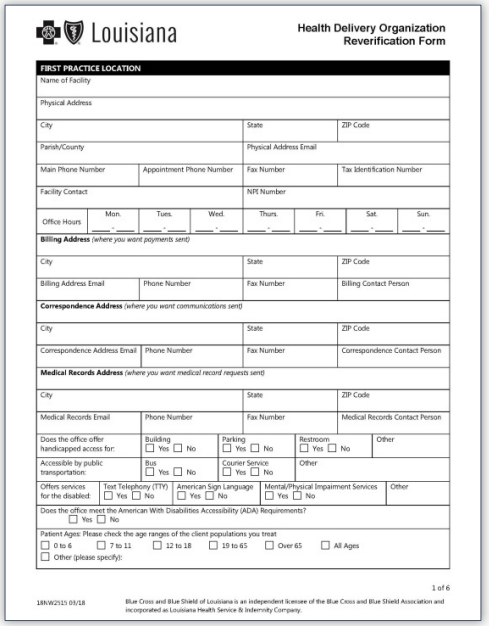
1 of 6

23006677 801/18

Blue Cross and Blue Shield of Louisiana is an Independent licensee of the Blue Cross and Blue Shield Association and incorporated as Louisiana Health Service & Indemnity Company.

This application is part of the **Facility (initial)** credentialing packet.

Current network providers seeking recredentialing should use our **Health Delivery Organization Reverification Form**.



Louisiana

Health Delivery Organization Reverification Form

FIRST PRACTICE LOCATION

Name of Facility

Physical Address

City | State | ZIP Code

Parish/County | Physical Address Email

Main Phone Number | Appointment Phone Number | Fax Number | Tax Identification Number

Facility Contact | NPI Number

Office Hours: Mon. ___ - ___ | Tues. ___ - ___ | Wed. ___ - ___ | Thurs. ___ - ___ | Fri. ___ - ___ | Sat. ___ - ___ | Sun. ___ - ___

Billing Address *(where you want payments sent)*

City | State | ZIP Code

Billing Address Email | Phone Number | Fax Number | Billing Contact Person

Correspondence Address *(where you want communications sent)*

City | State | ZIP Code

Correspondence Address Email | Phone Number | Fax Number | Correspondence Contact Person

Medical Records Address *(where you want medical record requests sent)*

City | State | ZIP Code

Medical Records Email | Phone Number | Fax Number | Medical Records Contact Person

Does the office offer handicapped access for: Building ☐ Yes ☐ No | Parking ☐ Yes ☐ No | Restroom ☐ Yes ☐ No | Other

Accessible by public transportation: Bus ☐ Yes ☐ No | Courier Service ☐ Yes ☐ No | Other

Offers services for the disabled: Text Telephony (TTY) ☐ Yes ☐ No | American Sign Language ☐ Yes ☐ No | Mental/Physical Impairment Services ☐ Yes ☐ No | Other

Does the office meet the American With Disabilities Accessibility (ADA) Requirements? ☐ Yes ☐ No

Patient Ages: Please check the age ranges of the client populations you treat
☐ 0 to 6 ☐ 7 to 11 ☐ 12 to 18 ☐ 19 to 65 ☐ Over 65 ☐ All Ages
☐ Other (please specify):

1 of 6

18NW2515 03/18

Blue Cross and Blue Shield of Louisiana is an Independent licensee of the Blue Cross and Blue Shield Association and incorporated as Louisiana Health Service & Indemnity Company.

This application is part of the **Facility (reverification)** packet.

Find our credentialing links at **www.BCBSLA.com/providers** >Provider Networks >Join Our Networks.

Required Credentialing Forms for Facilities

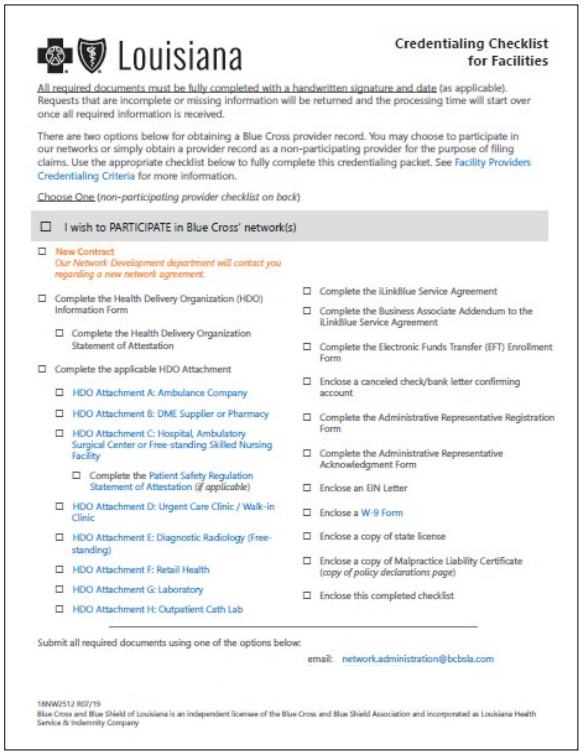
The **HDO Information Form** may also require an HDO attachment as indicated by facility type:

- HDO Attachment A: Ambulance Company
- HDO Attachment B: DME Supplier or Pharmacy
- HDO Attachment C: Hospital, Ambulatory Surgical Center or Free-standing Skilled Nursing Facilities
- HDO Attachment D: Urgent Care Clinic/Walk-In Clinic
- HDO Attachment E: Diagnostic Radiology (Free-standing)
- HDO Attachment F: Retail Health Clinics
- HDO Attachment G: Laboratory
- HDO Attachment H: Outpatient Cath Lab

Hospital-based Providers

- A hospital-based provider is defined as a provider that **only** sees patients as a result of their being admitted or directed to the hospital.
- A provider is NOT considered hospital-based if you have patients referred directly to you from another physician or organization or if the member can make an appointment with the physician.
- The classification as a hospital-based provider applies for the hospital location only and NOT for any other practice locations outside the hospital.
- Hospital-based providers can be allowed to participate in our networks without credentialing requirements. We do not list those providers in the directory and allow the hospital's credentialing to stand.

Required Supporting Documentation for Facilities



Louisiana

Credentialing Checklist for Facilities

All required documents must be fully completed with a handwritten signature and date (as applicable). Requests that are incomplete or missing information will be returned and the processing time will start over once all required information is received.

There are two options below for obtaining a Blue Cross provider record. You may choose to participate in our networks or simply obtain a provider record as a non-participating provider for the purpose of filing claims. Use the appropriate checklist below to fully complete this credentialing packet. See Facility Providers Credentialing Criteria for more information.

Choose One (*non-participating provider checklist on back*)

☐ I wish to PARTICIPATE in Blue Cross' network(s)

- ☐ New Contract
  Our Network Development department will contact you regarding a new network agreement.
- ☐ Complete the Health Delivery Organization (HDO) Information Form
  - ☐ Complete the Health Delivery Organization Statement of Attestation
- ☐ Complete the applicable HDO Attachment
  - ☐ HDO Attachment A: Ambulance Company
  - ☐ HDO Attachment B: DME Supplier or Pharmacy
  - ☐ HDO Attachment C: Hospital, Ambulatory Surgical Center or Free-standing Skilled Nursing Facility
    - ☐ Complete the Patient Safety Regulation Statement of Attestation (*if applicable*)
  - ☐ HDO Attachment D: Urgent Care Clinic / Walk-in Clinic
  - ☐ HDO Attachment E: Diagnostic Radiology (Free-standing)
  - ☐ HDO Attachment F: Retail Health
  - ☐ HDO Attachment G: Laboratory
  - ☐ HDO Attachment H: Outpatient Cath Lab
- ☐ Complete the iLinkBlue Service Agreement
- ☐ Complete the Business Associate Addendum to the iLinkBlue Service Agreement
- ☐ Complete the Electronic Funds Transfer (EFT) Enrollment Form
- ☐ Enclose a canceled check/bank letter confirming account
- ☐ Complete the Administrative Representative Registration Form
- ☐ Complete the Administrative Representative Acknowledgment Form
- ☐ Enclose an EIN Letter
- ☐ Enclose a W-9 Form
- ☐ Enclose a copy of state license
- ☐ Enclose a copy of Malpractice Liability Certificate (*copy of policy declarations page*)
- ☐ Enclose this completed checklist

Submit all required documents using one of the options below:

email: network.administration@bcbsla.com

18NW0512 R07/19

Blue Cross and Blue Shield of Louisiana is an independent licensee of the Blue Cross and Blue Shield Association and incorporated as Louisiana Health Service & Indemnity Company

- The Facility (initial) credentialing packet includes a checklist of all required documents.
- To **join our networks**, complete the checklist under "I wish to PARTICIPATE in Blue Cross' network(s)."
- If you **want a provider record only for filing claims**, complete the checklist under "I wish to obtain a Blue Cross record only as a NON-PARTICIPATING provider" (appears on Page 2 of checklist).

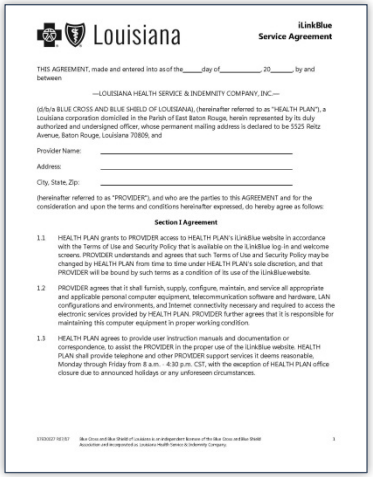
- **You must complete the applicable checklist and submit all indicated documents.**
- **Credentialing packets with incomplete, missing information or submitted incorrectly will be returned.**

iLinkBlue Application Packet

iLinkBlue is our secure online tool for professional and facility healthcare providers. It is designed to help you quickly complete important functions such as eligibility and coverage verification, claims filing and review, payment queries and transactions.

The **iLinkBlue Application Packet** is included in our credentialing packets. These documents are required to access iLinkBlue and become a participating provider.

Below are the four parts:


Louisiana

iLinkBlue Service Agreement

THIS AGREEMENT, made and entered into as of the_____day of_____, 20_____, by and between

—LOUISIANA HEALTH SERVICE & INDEMNITY COMPANY, INC.—

(d/b/a BLUE CROSS AND BLUE SHIELD OF LOUISIANA), (hereinafter referred to as "HEALTH PLAN"), a Louisiana corporation domiciled in the Parish of East Baton Rouge, herein represented by its duly authorized and undersigned officer, whose permanent mailing address is declared to be 5525 Reitz Avenue, Baton Rouge, Louisiana 70809, and

Provider Name: _____

Address: _____

City, State, Zip: _____

(hereinafter referred to as "PROVIDER"), and who are the parties to this AGREEMENT and for the consideration and upon the terms and conditions hereinafter expressed, do hereby agree as follows:

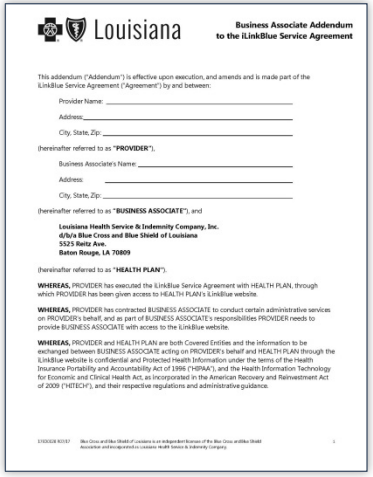
Section I Agreement

1.1 HEALTH PLAN grants to PROVIDER access to HEALTH PLAN's iLinkBlue website in accordance with the Terms of Use and Security Policy that is available on the iLinkBlue log-in and welcome screens. PROVIDER understands and agrees that such Terms of Use and Security Policy may be changed by HEALTH PLAN from time to time under HEALTH PLAN's sole discretion, and that PROVIDER will be bound by such terms as a condition of its use of the iLinkBlue website.

1.2 PROVIDER agrees that it shall furnish, supply, configure, maintain, and service all appropriate and applicable personal computer equipment, telecommunication software and hardware, LAN configurations and environments, and Internet connectivity necessary and required to access the electronic services provided by HEALTH PLAN. PROVIDER further agrees that it is responsible for maintaining this computer equipment in proper working condition.

1.3 HEALTH PLAN agrees to provide user instruction manuals and documentation or correspondence, to assist the PROVIDER in the proper use of the iLinkBlue website. HEALTH PLAN shall provide telephone and other PROVIDER support services it deems reasonable, Monday through Friday from 8 a.m. - 4:30 p.m. CST, with the exception of HEALTH PLAN office closure due to announced holidays or any unforeseen circumstances.

iLinkBlue Service Agreement


Louisiana

Business Associate Addendum to the iLinkBlue Service Agreement

This addendum ("Addendum") is effective upon execution, and amends and is made part of the iLinkBlue Service Agreement ("Agreement") by and between:

Provider Name: _____

Address: _____

City, State, Zip: _____

(hereinafter referred to as "**PROVIDER**"),

Business Associate's Name: _____

Address: _____

City, State, Zip: _____

(hereinafter referred to as "**BUSINESS ASSOCIATE**"), and

Louisiana Health Service & Indemnity Company, Inc.
d/b/a Blue Cross and Blue Shield of Louisiana
5525 Reitz Ave.
Baton Rouge, LA 70809

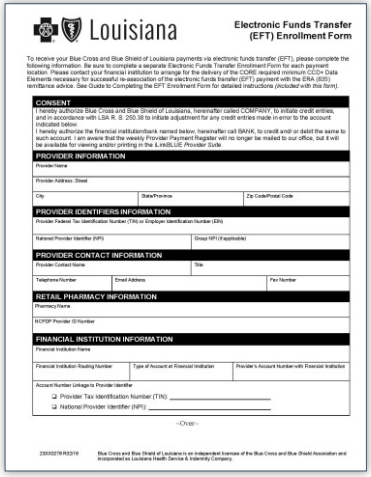
(hereinafter referred to as "**HEALTH PLAN**").

WHEREAS, PROVIDER has executed the iLinkBlue Service Agreement with HEALTH PLAN, through which PROVIDER has been given access to HEALTH PLAN's iLinkBlue website.

WHEREAS, PROVIDER has contracted BUSINESS ASSOCIATE to conduct certain administrative services on PROVIDER's behalf, and as part of BUSINESS ASSOCIATE's responsibilities PROVIDER needs to provide BUSINESS ASSOCIATE with access to the iLinkBlue website.

WHEREAS, PROVIDER and HEALTH PLAN are both Covered Entities and the information to be exchanged between BUSINESS ASSOCIATE acting on PROVIDER's behalf and HEALTH PLAN through the iLinkBlue website is confidential and Protected Health Information under the terms of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), and the Health Information Technology for Economic and Clinical Health Act, as incorporated in the American Recovery and Reinvestment Act of 2009 ("HITECH"), and their respective regulations and administrative guidance.

Business Associate Addendum


Louisiana

Electronic Funds Transfer (EFT) Enrollment Form

To receive your Blue Cross and Blue Shield of Louisiana payments via electronic funds transfer (EFT), please complete the following information. Be sure to complete a separate Electronic Funds Transfer Enrollment Form for each payment location. Please contact your financial institution to arrange for the delivery of the CORE required minimum CCD+ Data Elements necessary for successful re-association of the electronic funds transfer (EFT) payment with the ERA (835) remittance advice. See Guide to Completing the EFT Enrollment Form for detailed instructions (included with this form).

CONSENT

I hereby authorize Blue Cross and Blue Shield of Louisiana, hereinafter called COMPANY, to initiate credit entries, and in accordance with LSA R. S. 250.38 to initiate adjustment for any credit entries made in error to the account indicated below.
I hereby authorize the financial institution/bank named below, hereinafter call BANK, to credit and/or debit the same to such account. I am aware that the weekly Provider Payment Register will no longer be mailed to our office, but it will be available for viewing and/or printing in the iLinkBLUE *Provider Suite*.

PROVIDER INFORMATION

Provider Name

Provider Address: Street

City | State/Province | Zip Code/Postal Code

PROVIDER IDENTIFIERS INFORMATION

Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN)

National Provider Identifier (NPI) | Group NPI (if applicable)

PROVIDER CONTACT INFORMATION

Provider Contact Name | Title

Telephone Number | Email Address | Fax Number

RETAIL PHARMACY INFORMATION

Pharmacy Name

NCPDP Provider ID Number

FINANCIAL INSTITUTION INFORMATION

Financial Institution Name

Financial Institution Routing Number | Type of Account at Financial Institution | Provider's Account Number with Financial Institution

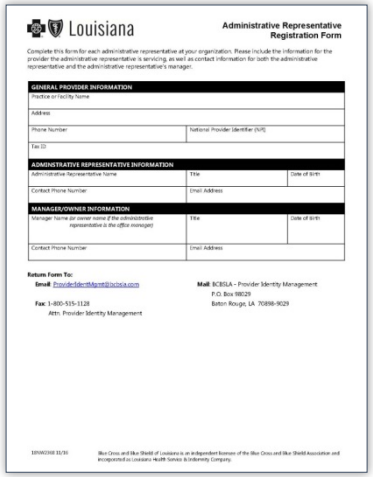
Account Number Linkage to Provider Identifier

❑ Provider Tax Identification Number (TIN) _____

❑ National Provider Identifier (NPI) _____

–Over–

Electronic Funds Transfer (EFT) Enrollment Form


Louisiana

Administrative Representative Registration Form

Complete this form for each administrative representative at your organization. Please include the information for the provider the administrative representative is servicing, as well as contact information for both the administrative representative and the administrative representative's manager.

GENERAL PROVIDER INFORMATION

Practice or Facility Name

Address

Phone Number | National Provider Identifier (NPI)

Tax ID

ADMINISTRATIVE REPRESENTATIVE INFORMATION

Administrative Representative Name | Title | Date of Birth

Contact Phone Number | Email Address

MANAGER/OWNER INFORMATION

Manager Name (or owner name if the administrative representative is the office manager) | Title | Date of Birth

Contact Phone Number | Email Address

Return Form To:

Email: ProviderIdentityMgmt@bcbsla.com

Fax: 1-800-515-1128
Attn: Provider Identity Management

Mail: BCBSLA - Provider Identity Management
P.O. Box 98029
Baton Rouge, LA 70898-9029

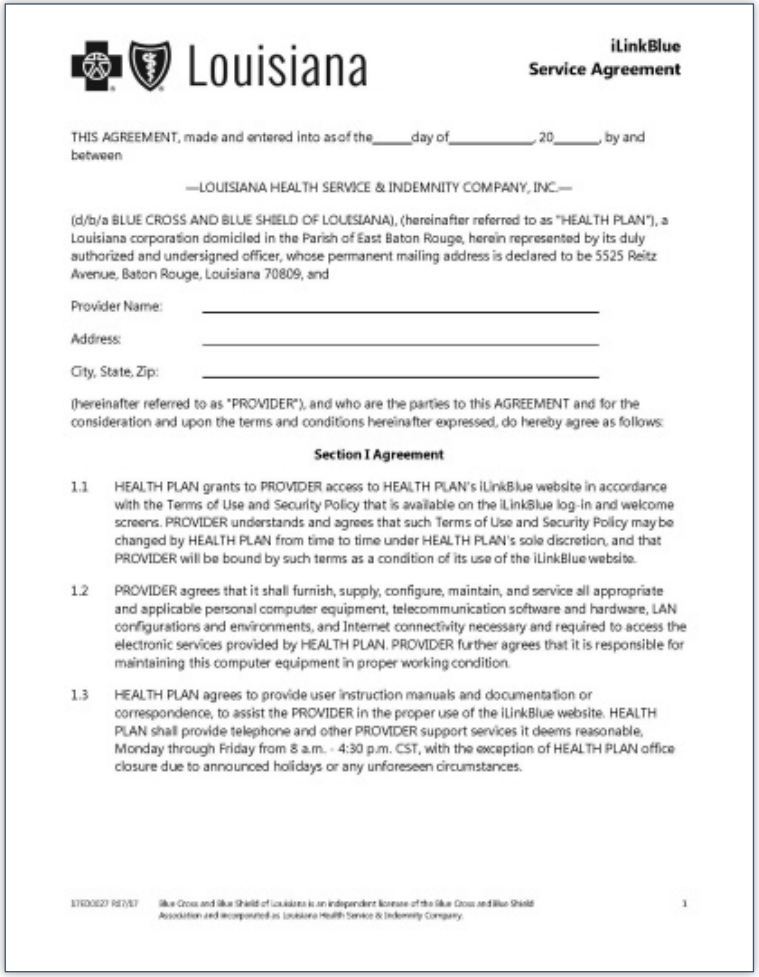
Administrative Representative Registration Form

The iLinkBlue Application Packet is also available online at **www.BCBSLA.com/providers** >Electronic Services >iLinkBlue.

iLinkBlue Application Packet

Included in the iLinkBlue packet:

The **iLinkBlue Service Agreement** is a legal agreement between the provider and Blue Cross and Blue Shield of Louisiana required for accessing iLinkBlue.



Louisiana

iLinkBlue Service Agreement

THIS AGREEMENT, made and entered into as of the_____day of_____, 20_____, by and between

—LOUISIANA HEALTH SERVICE & INDEMNITY COMPANY, INC.—

(d/b/a BLUE CROSS AND BLUE SHIELD OF LOUISIANA), (hereinafter referred to as "HEALTH PLAN"), a Louisiana corporation domiciled in the Parish of East Baton Rouge, herein represented by its duly authorized and undersigned officer, whose permanent mailing address is declared to be 5525 Reitz Avenue, Baton Rouge, Louisiana 70809, and

Provider Name: _____

Address: _____

City, State, Zip: _____

(hereinafter referred to as "PROVIDER"), and who are the parties to this AGREEMENT and for the consideration and upon the terms and conditions hereinafter expressed, do hereby agree as follows:

Section I Agreement

1.1 HEALTH PLAN grants to PROVIDER access to HEALTH PLAN's iLinkBlue website in accordance with the Terms of Use and Security Policy that is available on the iLinkBlue log-in and welcome screens. PROVIDER understands and agrees that such Terms of Use and Security Policy may be changed by HEALTH PLAN from time to time under HEALTH PLAN's sole discretion, and that PROVIDER will be bound by such terms as a condition of its use of the iLinkBlue website.

1.2 PROVIDER agrees that it shall furnish, supply, configure, maintain, and service all appropriate and applicable personal computer equipment, telecommunication software and hardware, LAN configurations and environments, and Internet connectivity necessary and required to access the electronic services provided by HEALTH PLAN. PROVIDER further agrees that it is responsible for maintaining this computer equipment in proper working condition.

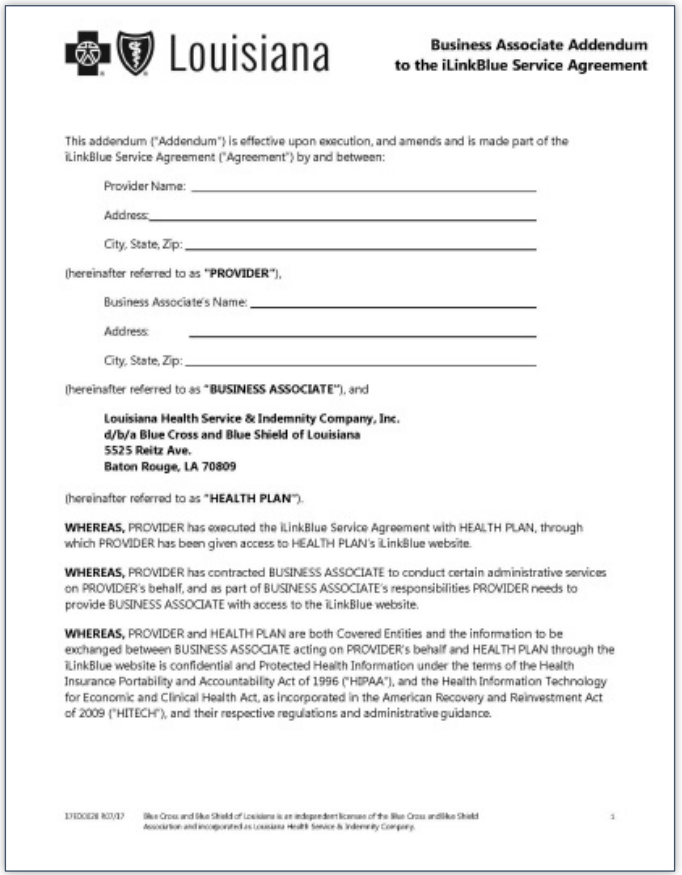
1.3 HEALTH PLAN agrees to provide user instruction manuals and documentation or correspondence, to assist the PROVIDER in the proper use of the iLinkBlue website. HEALTH PLAN shall provide telephone and other PROVIDER support services it deems reasonable, Monday through Friday from 8 a.m. - 4:30 p.m. CST, with the exception of HEALTH PLAN office closure due to announced holidays or any unforeseen circumstances.

iLinkBlue Application Packet

Included in the iLinkBlue packet:

- The **Business Associate Addendum** is used to grant third-party agents such as a billing agency or management company access to iLinkBlue under the provider's iLinkBlue Service Agreement.

- It is required only if the provider uses a billing agency or management company that will need to access iLinkBlue on behalf of the provider.



Louisiana

Business Associate Addendum to the iLinkBlue Service Agreement

This addendum ("Addendum") is effective upon execution, and amends and is made part of the iLinkBlue Service Agreement ("Agreement") by and between:

Provider Name: _____

Address: _____

City, State, Zip: _____

(hereinafter referred to as "**PROVIDER**"),

Business Associate's Name: _____

Address: _____

City, State, Zip: _____

(hereinafter referred to as "**BUSINESS ASSOCIATE**"), and

Louisiana Health Service & Indemnity Company, Inc.
d/b/a Blue Cross and Blue Shield of Louisiana
5525 Reitz Ave.
Baton Rouge, LA 70809

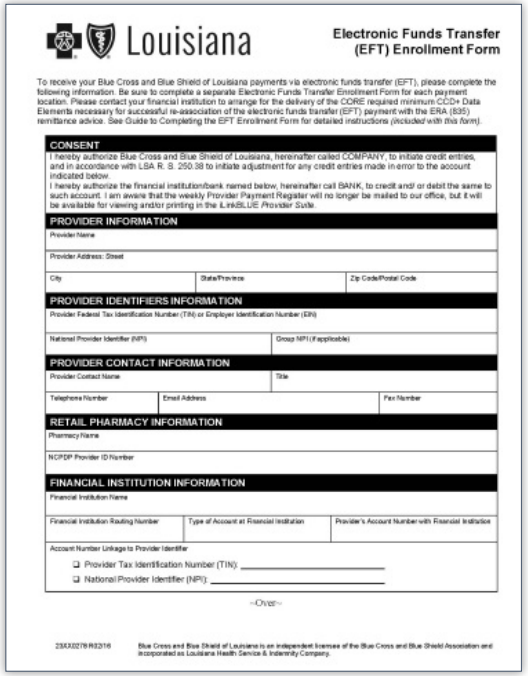
(hereinafter referred to as "**HEALTH PLAN**").

WHEREAS, PROVIDER has executed the iLinkBlue Service Agreement with HEALTH PLAN, through which PROVIDER has been given access to HEALTH PLAN's iLinkBlue website.

WHEREAS, PROVIDER has contracted BUSINESS ASSOCIATE to conduct certain administrative services on PROVIDER's behalf, and as part of BUSINESS ASSOCIATE's responsibilities PROVIDER needs to provide BUSINESS ASSOCIATE with access to the iLinkBlue website.

WHEREAS, PROVIDER and HEALTH PLAN are both Covered Entities and the information to be exchanged between BUSINESS ASSOCIATE acting on PROVIDER's behalf and HEALTH PLAN through the iLinkBlue website is confidential and Protected Health Information under the terms of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), and the Health Information Technology for Economic and Clinical Health Act, as incorporated in the American Recovery and Reinvestment Act of 2009 ("HITECH"), and their respective regulations and administrative guidance.

Electronic Funds Transfer (EFT) Enrollment Form



Louisiana

Electronic Funds Transfer (EFT) Enrollment Form

To receive your Blue Cross and Blue Shield of Louisiana payments via electronic funds transfer (EFT), please complete the following information. Be sure to complete a separate Electronic Funds Transfer Enrollment Form for each payment location. Please contact your financial institution to arrange for the delivery of the CORE required minimum CCD+ Data Elements necessary for successful re-association of the electronic funds transfer (EFT) payment with the ERA (835) remittance advice. See Guide to Completing the EFT Enrollment Form for detailed instructions *(included with this form)*.

CONSENT

I hereby authorize Blue Cross and Blue Shield of Louisiana, hereinafter called COMPANY, to initiate credit entries, and in accordance with LSA R. S. 250.38 to initiate adjustment for any credit entries made in error to the account indicated below.

I hereby authorize the financial institution/bank named below, hereinafter call BANK, to credit and/ or debit the same to such account. I am aware that the weekly Provider Payment Register will no longer be mailed to our office, but it will be available for viewing and/or printing in the *iLinkBLUE Provider Suite*.

PROVIDER INFORMATION

Provider Name

Provider Address: Street

City | State/Province | Zip Code/Postal Code

PROVIDER IDENTIFIERS INFORMATION

Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN)

National Provider Identifier (NPI) | Group NPI (If applicable)

PROVIDER CONTACT INFORMATION

Provider Contact Name | Title

Telephone Number | Email Address | Fax Number

RETAIL PHARMACY INFORMATION

Pharmacy Name

NCPDP Provider ID Number

FINANCIAL INSTITUTION INFORMATION

Financial Institution Name

Financial Institution Routing Number | Type of Account at Financial Institution | Provider's Account Number with Financial Institution

Account Number Linkage to Provider Identifier

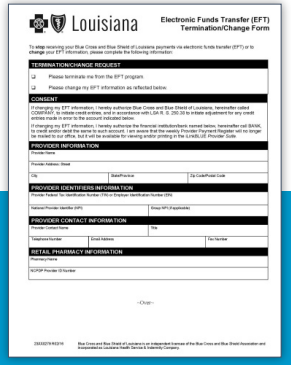
- ❑ Provider Tax Identification Number (TIN): _____
- ❑ National Provider Identifier (NPI): _____

~Over~

23AX0279 R03/16 Blue Cross and Blue Shield of Louisiana is an independent licensee of the Blue Cross and Blue Shield Association and incorporated as Louisiana Health Service & Indemnity Company.

- EFT is a free provider service where Blue Cross deposits your payment directly into your checking account.
- With iLinkBlue, you have access to EFT notifications and Payment Registers/Remittance Advices (can be printed directly).
- All Blue Cross providers **must** be part of our EFT program, including those signed up for iLinkBlue.
- The EFT Enrollment Form includes a guide with detailed instructions on how to complete the form.

These forms are also available online at
www.BCBSLA.com/providers >Resources >Forms.



Louisiana

Electronic Funds Transfer (EFT) Termination/Change Form

TERMINATION/CHANGE REQUEST

❑ Please terminate me from the EFT program.

❑ Please change my EFT information as reflected below.

CONSENT

If changing my EFT information, I hereby authorize Blue Cross and Blue Shield of Louisiana, hereinafter called COMPANY, to initiate credit entries, and in accordance with LSA R. S. 250.38 to initiate adjustment for any credit entries made in error to the account indicated below.

If changing my EFT information, I hereby authorize the financial institution/bank named below, hereinafter call BANK, to credit and/or debit the same to such account. I am aware that the weekly Provider Payment Register will no longer be mailed to our office, but it will be available for viewing and/or printing in the *iLinkBLUE Provider Suite*.

PROVIDER INFORMATION

Provider Name

Provider Address: Street

City | State/Province | Zip Code/Postal Code

PROVIDER IDENTIFIERS INFORMATION

Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN)

National Provider Identifier (NPI) | Group NPI (If applicable)

PROVIDER CONTACT INFORMATION

Provider Contact Name | Title

Telephone Number | Email Address | Fax Number

RETAIL PHARMACY INFORMATION

Pharmacy Name

NCPDP Provider ID Number

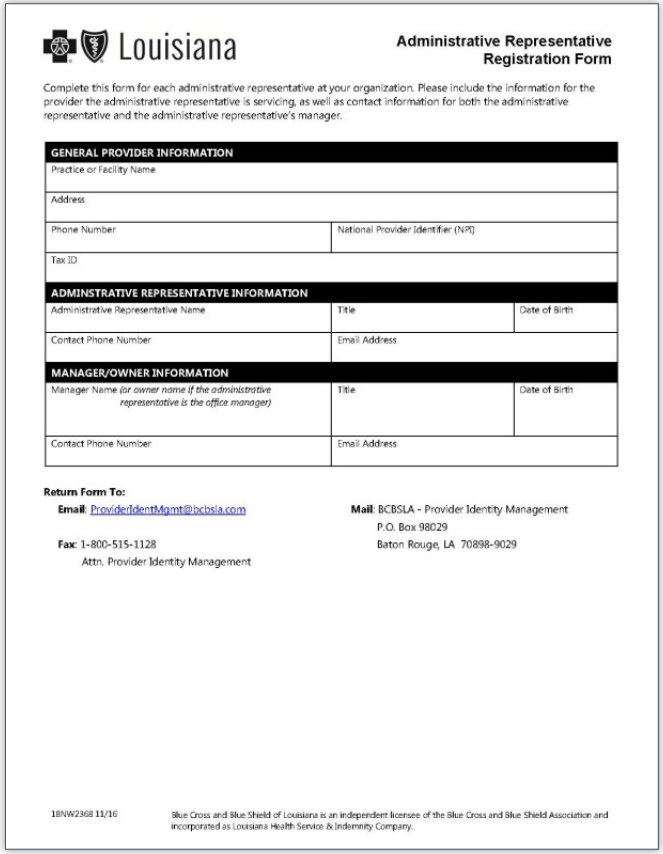
~Over~

23AX0279 R03/16 Blue Cross and Blue Shield of Louisiana is an independent licensee of the Blue Cross and Blue Shield Association and incorporated as Louisiana Health Service & Indemnity Company.

To change or update your Blue Cross payments via EFT, complete the EFT Termination/Change Form.

Administrative Representative Registration

- We require that each provider organization designate at least one administrative representative to self-manage user access to our secure online services.
- Your administrative representative is responsible for managing your secure access to the following Blue Cross online services:
  - iLinkBlue
  - BCBSLA authorizations
  - Behavioral health authorizations
  - Pre-service review for out-of-area members (BlueCard® members)
  - and more
- If you are part of a provider group or facility that already has registered an administrative representative with Blue Cross, you do not have to submit the Administrative Representative Registration Form.



Louisiana

Administrative Representative Registration Form

Complete this form for each administrative representative at your organization. Please include the information for the provider the administrative representative is servicing, as well as contact information for both the administrative representative and the administrative representative's manager.

GENERAL PROVIDER INFORMATION		
Practice or Facility Name		
Address		
Phone Number	National Provider Identifier (NPI)	
Tax ID		
ADMINSTRATIVE REPRESENTATIVE INFORMATION		
Administrative Representative Name	Title	Date of Birth
Contact Phone Number	Email Address	
MANAGER/OWNER INFORMATION		
Manager Name *(or owner name if the administrative representative is the office manager)*	Title	Date of Birth
Contact Phone Number	Email Address	

Return Form To:

Email: ProviderIdentMgmt@bcbsla.com

Fax: 1-800-515-1128
Attn. Provider Identity Management

Mail: BCBSLA - Provider Identity Management
P.O. Box 98029
Baton Rouge, LA 70898-9029

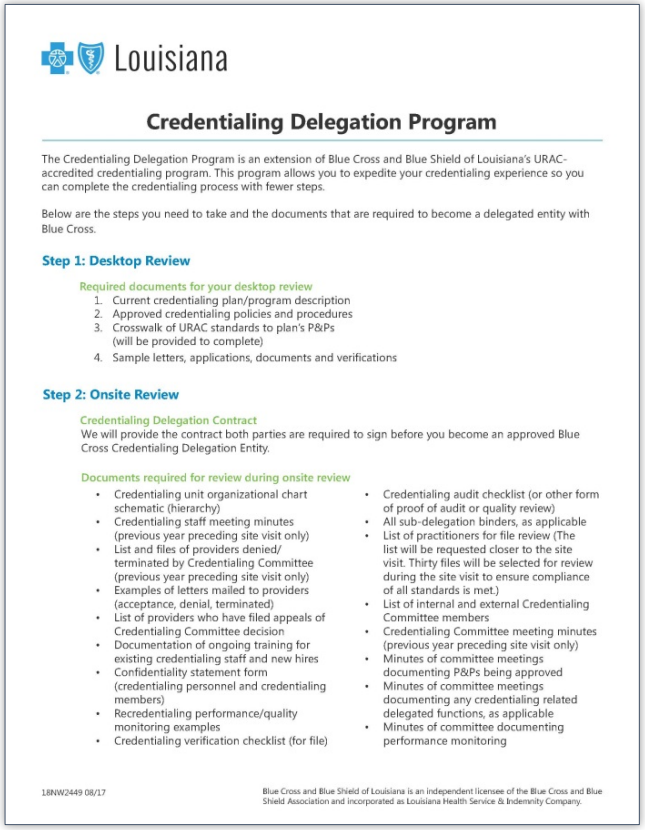
18NW2368 11/16

Blue Cross and Blue Shield of Louisiana is an independent licensee of the Blue Cross and Blue Shield Association and incorporated as Louisiana Health Service & Indemnity Company.

The Administrative Representative Registration Form is also available online at **www.BCBSLA.com/providers** >Electronic Services >Admin Reps.

Credentialing Delegation Program

- The Credentialing Delegation Program is an extension of our accredited credentialing program.
- An approved delegation entity essentially credentials its own providers and sends the information to Blue Cross to create their provider records.
- This program allows you to expedite your credentialing experience so you can complete the Blue Cross credentialing process with fewer steps.
- Available to groups with 50 or more practitioners.
- After a provider group is approved as a delegation entity, it will not be necessary to submit provider applications to be set up in the Blue Cross system.
- The *Credentialing Delegation Program* guide explains the steps network provider groups must take and the documents required to become a delegated entity.
- If you have any questions about the Credentialing Delegation Program, please email **credentialing.delegation@bcbsla.com**.



Louisiana

Credentialing Delegation Program

The Credentialing Delegation Program is an extension of Blue Cross and Blue Shield of Louisiana's URAC-accredited credentialing program. This program allows you to expedite your credentialing experience so you can complete the credentialing process with fewer steps.

Below are the steps you need to take and the documents that are required to become a delegated entity with Blue Cross.

Step 1: Desktop Review

Required documents for your desktop review

1. Current credentialing plan/program description
2. Approved credentialing policies and procedures
3. Crosswalk of URAC standards to plan's P&Ps (will be provided to complete)
4. Sample letters, applications, documents and verifications

Step 2: Onsite Review

Credentialing Delegation Contract

We will provide the contract both parties are required to sign before you become an approved Blue Cross Credentialing Delegation Entity.

Documents required for review during onsite review

- Credentialing unit organizational chart schematic (hierarchy)
- Credentialing staff meeting minutes (previous year preceding site visit only)
- List and files of providers denied/ terminated by Credentialing Committee (previous year preceding site visit only)
- Examples of letters mailed to providers (acceptance, denial, terminated)
- List of providers who have filed appeals of Credentialing Committee decision
- Documentation of ongoing training for existing credentialing staff and new hires
- Confidentiality statement form (credentialing personnel and credentialing members)
- Recredentialing performance/quality monitoring examples
- Credentialing verification checklist (for file)
- Credentialing audit checklist (or other form of proof of audit or quality review)
- All sub-delegation binders, as applicable
- List of practitioners for file review (The list will be requested closer to the site visit. Thirty files will be selected for review during the site visit to ensure compliance of all standards is met.)
- List of internal and external Credentialing Committee members
- Credentialing Committee meeting minutes (previous year preceding site visit only)
- Minutes of committee meetings documenting P&Ps being approved
- Minutes of committee meetings documenting any credentialing related delegated functions, as applicable
- Minutes of committee documenting performance monitoring

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The *Credentialing Delegation Program* guide is available online at **www.BCBSLA.com/providers** >Provider Networks >Join Our Networks.

Provider Directory

Keeping your information up to date with us is extremely important to help our members find you.

We publish demographic information in our online provider directory. The directory is available on our website at **www.BCBSLA.com**.

It is the contractual responsibility of all participating providers to contact Provider Credentialing & Data Management to update your information as soon as it changes. This includes:

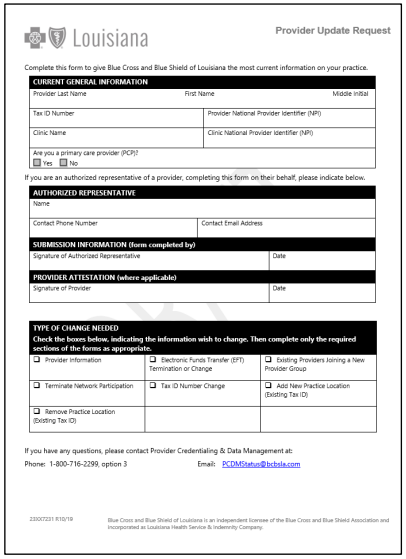
- Addresses (location information)
- Phone numbers
- Accepting new patients
- Providers working at certain locations
  - In order to be listed in the directory, professional providers must be available to schedule patients' appointments a minimum of 16 hours per week at the location listed.

To improve the accuracy of our online provider directory, we are making changes to help create the most accurate directory for our members.

Our Provider Credentialing & Data Management team will be working with you to help ensure your information is current and accurate.

How to Update Your Information

It is important that we always have your most current information. Our revised **Provider Update Request Form** now accommodates all your change requests, which are handled directly by our Provider Data Management team.



Louisiana

Provider Update Request

Complete this form to give Blue Cross and Blue Shield of Louisiana the most current information on your practice.

CURRENT GENERAL INFORMATION

Provider Last Name | First Name | Middle Initial

Tax ID Number | Provider National Provider Identifier (NPI)

Clinic Name | Clinic National Provider Identifier (NPI)

Are you a primary care provider (PCP)?
☐ Yes ☐ No

If you are an authorized representative of a provider, completing this form on their behalf, please indicate below.

AUTHORIZED REPRESENTATIVE

Name

Contact Phone Number | Contact Email Address

SUBMISSION INFORMATION (form completed by)

Signature of Authorized Representative | Date

PROVIDER ATTESTATION (where applicable)

Signature of Provider | Date

TYPE OF CHANGE NEEDED

Check the boxes below, indicating the information wish to change. Then complete only the required sections of the forms as appropriate.

☐ Provider Information	☐ Electronic Funds Transfer (EFT) Termination or Change	☐ Existing Providers Joining a New Provider Group
☐ Terminate Network Participation	☐ Tax ID Number Change	☐ Add New Practice Location (Existing Tax ID)
☐ Remove Practice Location (Existing Tax ID)		

If you have any questions, please contact Provider Credentialing & Data Management at:
Phone: 1-800-716-2299, option 3 Email: PCDMStatus@bcbsla.com

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When you access the form, check the appropriate box to indicate the type of change needed. You may select more than one option.

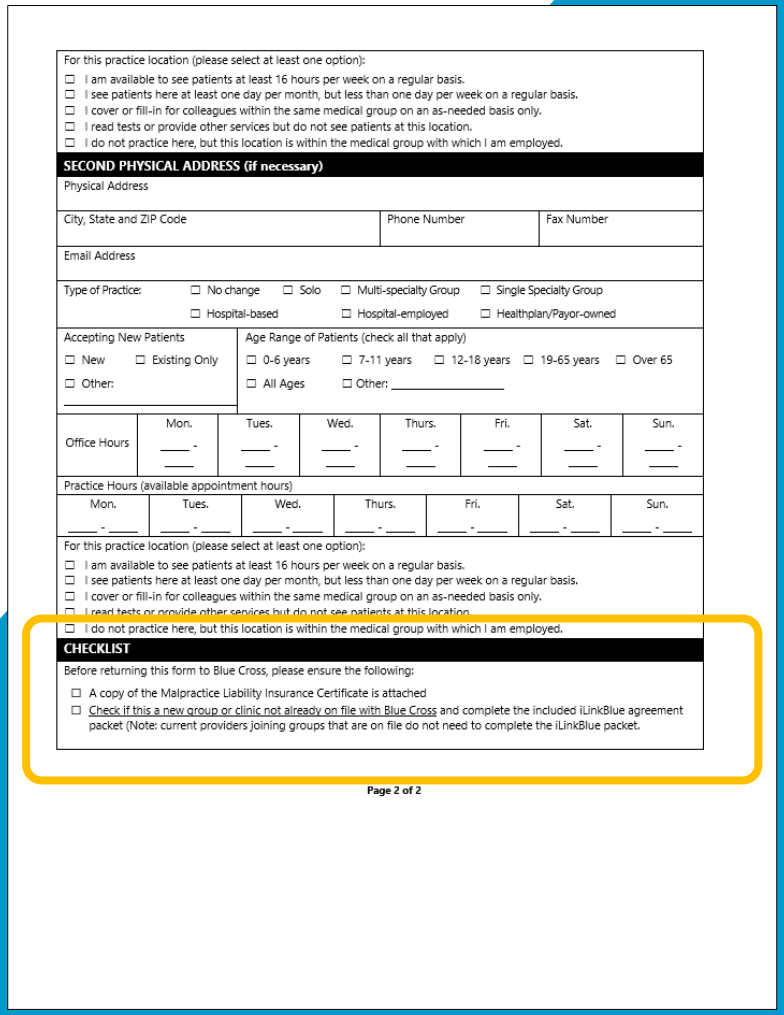
- **Provider Information** allows you to update your address, phone, fax, email address, hours of operation and more.
- **EFT Termination or Change** option is to update your EFT information.
- **Existing Providers Joining a New Provider Group** is used to link an individual provider to an existing provider group or clinic.
- **Terminate Network Participation** is to request termination from one or more of our networks.
- **Tax ID Number Change** is to report a change in your Tax ID number.
- **Add a New Practice Location** is for when a provider is adding practice location(s) on an existing Tax ID.
- **Remove Practice Location** is for when a provider is removing a practice location(s) on an existing Tax ID.

This form link is available online at **www.BCBSLA.com/providers** >Resources >Forms.

How to Update Your Information

Complete the checklist:

- Some changes on our Provider Update Request Form include a checklist of **required** supporting documentation needed to complete your request.
- Please ensure **all** requested items on the checklist are included or completed before submitting.
- Submissions that are missing checklist items will be returned.



For this practice location (please select at least one option):

☐ I am available to see patients at least 16 hours per week on a regular basis.
☐ I see patients here at least one day per month, but less than one day per week on a regular basis.
☐ I cover or fill-in for colleagues within the same medical group on an as-needed basis only.
☐ I read tests or provide other services but do not see patients at this location.
☐ I do not practice here, but this location is within the medical group with which I am employed.

SECOND PHYSICAL ADDRESS (if necessary)

Physical Address

City, State and ZIP Code | Phone Number | Fax Number

Email Address

Type of Practice: ☐ No change ☐ Solo ☐ Multi-specialty Group ☐ Single Specialty Group ☐ Hospital-based ☐ Hospital-employed ☐ Healthplan/Payor-owned

Accepting New Patients
☐ New ☐ Existing Only
☐ Other:

Age Range of Patients (check all that apply)
☐ 0-6 years ☐ 7-11 years ☐ 12-18 years ☐ 19-65 years ☐ Over 65
☐ All Ages ☐ Other: _____

	Mon.	Tues.	Wed.	Thurs.	Fri.	Sat.	Sun.
Office Hours	____ - ____	____ - ____	____ - ____	____ - ____	____ - ____	____ - ____	____ - ____

Practice Hours (available appointment hours)

Mon.	Tues.	Wed.	Thurs.	Fri.	Sat.	Sun.
____ - ____	____ - ____	____ - ____	____ - ____	____ - ____	____ - ____	____ - ____

For this practice location (please select at least one option):

☐ I am available to see patients at least 16 hours per week on a regular basis.
☐ I see patients here at least one day per month, but less than one day per week on a regular basis.
☐ I cover or fill-in for colleagues within the same medical group on an as-needed basis only.
☐ I read tests or provide other services but do not see patients at this location.
☐ I do not practice here, but this location is within the medical group with which I am employed.

CHECKLIST

Before returning this form to Blue Cross, please ensure the following:

☐ A copy of the Malpractice Liability Insurance Certificate is attached
☐ Check if this a new group or clinic not already on file with Blue Cross and complete the included iLinkBlue agreement packet (Note: current providers joining groups that are on file do not need to complete the iLinkBlue packet.

Page 2 of 2

Provider Credentialing & Data Management (PCDM)

Provider Network Setup, Credentialing & Demographic Change

Justin Bright Director – **justin.bright@bcbsla.com**

Mary Reising Manager - **mary.reising@bcbsla.com**

Anne Monroe Provider Information Supervisor - **anne.monroe@bcbsla.com**

Rhonda Dyer Provider Information Supervisor - **rhonda.dyer@bcbsla.com**

If you would like to check the status on your credentialing application or provider data change or update, please contact the Provider Credentialing & Data Management Department by emailing **pcdmstatus@bcbsla.com** or by calling 1-800-716-2299, option 2.

ADDRESSING YOUR

At this time, we will address the questions you submitted electronically through the webinar platform.

You may also email questions after the webinar to provider.relations@bcbsla.com.