

# Provider Credentialing & Data Management Webinar

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

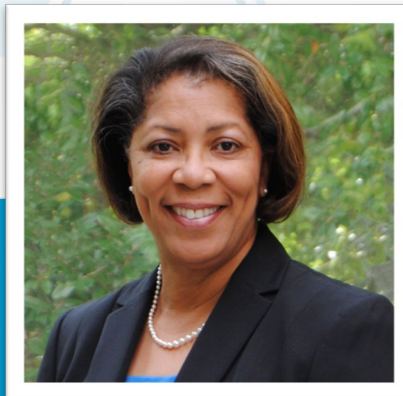
- This helps prevent background noise (e.g., unmuted phones or phones put on hold) during the webinar.
- This also means we are unable to hear you during the webinar.
- Please submit your questions directly through the webinar platform only.



## How to submit questions:

- Open the Q&A feature at the bottom of your screen, type your question related to today's training webinar and hit "enter."
- Once your question is answered, it will appear in the "Answered" tab.
- All questions will be answered by the end of the webinar.

# PROVIDER CREDENTIALING & DATA MANAGEMENT



September 2022

**Melonie Martin**  
**Provider Relations**



HMO Louisiana, Inc. is a subsidiary of Blue Cross and Blue Shield of Louisiana. Both companies are independent licensees of the Blue Cross Blue Shield Association.

Vantage is a Louisiana-based company that is partnered with Blue Cross and Blue Shield of Louisiana (Blue Cross), including HMO Louisiana, Inc., to credential and recredential our network providers.

# Vantage Health Plan

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Blue Cross is pleased to announce its partnership with Vantage Health Plan, Inc. to credential our network providers. This move will simplify the recredentialing experience for many of our providers.

Since February 2022 this move now includes:

- **initial credentialing for professional providers** and
- **initial and recredentialing for Blue Cross facility providers.**



# Credentialing Overview

# Joining Our Networks

There are two types of Blue Cross provider records a provider can obtain:

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](http://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. With the exception of services covered under the No Surprises Act.
- 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

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- 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 initial 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.

Inquire about your initial credentialing status by contacting our Provider Credentialing & Data Management (PCDM) Department at **[PCDMStatus@bcbsla.com](mailto:PCDMStatus@bcbsla.com)**.



# Credentialing Committee

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## 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.



# 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](mailto: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**

<ul style="list-style-type: none"><li>• Credentialing unit organizational chart schematic (hierarchy)</li><li>• Credentialing staff meeting minutes (previous year preceding site visit only)</li><li>• List and files of providers denied/terminated by Credentialing Committee (previous year preceding site visit only)</li><li>• Examples of letters mailed to providers (acceptance, denial, terminated)</li><li>• List of providers who have filed appeals of Credentialing Committee decision</li><li>• Documentation of ongoing training for existing credentialing staff and new hires</li><li>• Confidentiality statement form (credentialing personnel and credentialing members)</li><li>• Recredentialing performance/quality monitoring examples</li><li>• Credentialing verification checklist (for file)</li></ul>	<ul style="list-style-type: none"><li>• Credentialing audit checklist (or other form of proof of audit or quality review)</li><li>• All sub-delegation binders, as applicable</li><li>• 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.)</li><li>• List of internal and external Credentialing Committee members</li><li>• Credentialing Committee meeting minutes (previous year preceding site visit only)</li><li>• Minutes of committee meetings documenting P&amp;Ps being approved</li><li>• Minutes of committee meetings documenting any credentialing related delegated functions, as applicable</li><li>• Minutes of committee documenting performance monitoring</li></ul>
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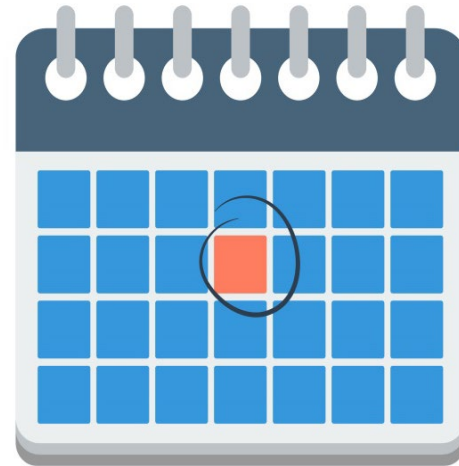
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# Effective Dates

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## **For non-participating providers** (requesting a provider record only):

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 participating providers:

We cannot retroactively allow network participation prior to a provider’s credentialing date. Our accrediting organization strictly prohibits it. Effective dates are based on:

Delegation Program Providers	New Providers Not Credentialed	Providers Already Credentialed
The effective date for delegated providers is based on approval of the Credentialing Delegation spreadsheet by our Medical Director.	<p>If you are eligible for reimbursement during credentialing (joining an existing contracted group), then it is one month prior to the date of receipt of application; <b>OR</b></p> <p>If you are not eligible for reimbursement during credentialing, then it is the approved date by the Credentialing Committee <b>AND</b> the execution of your network agreement.</p>	<p>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.</p> <p>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.</p>

Louisiana law allows professional provider types to request that Blue Cross reimburse claims during the credentialing process as if a network provider. This special provision effective date can be retroactive up to one month from the date we received the application and request. **The next slide includes new updates to this provision.**

# Reimbursement During Credentialing

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The Consolidated Appropriations Act (CAA) 2021\* includes new guidelines, effective January 1, 2022, for Reimbursement During Credentialing as it applies to all professional providers. Blue Cross already offered this expanded level to our providers.

Reimbursement During Credentialing will be granted to all professional providers **joining an existing contracted provider group**. This allows for in-network reimbursement on submitted claims during the credentialing process.

This provision does not apply for solo practitioners.

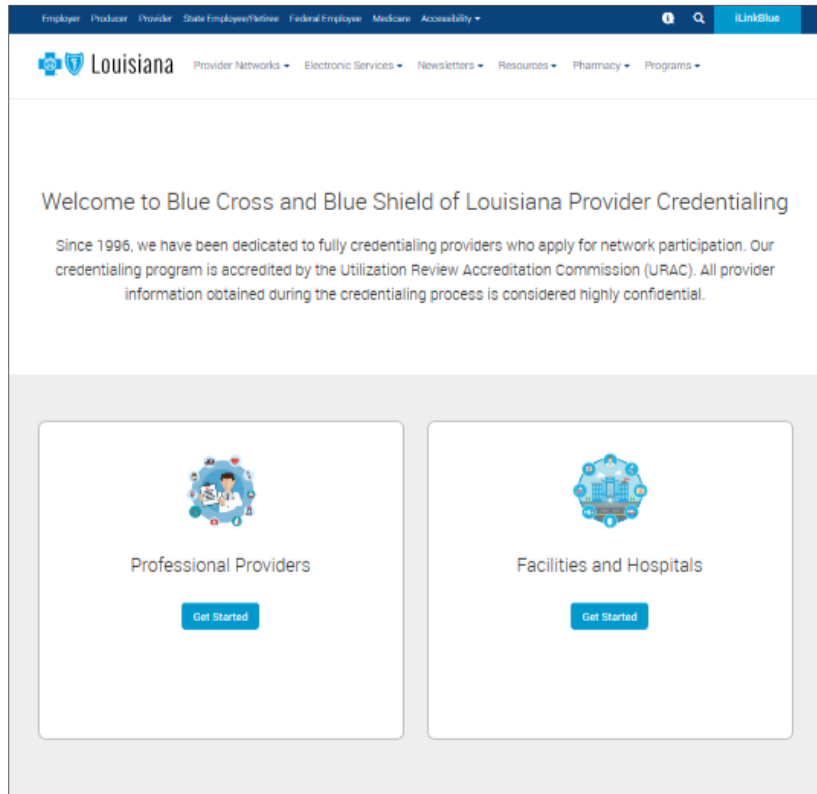


**Providers should not file/submit claims until** receiving a provider number letter from our PCDM Department notifying you of the Reimbursement During Credentialing effective date. If you have any questions about the Reimbursement During Credentialing Process, contact PCDM at 1-800-716-2299, option 2 or **[PCDMStatus@bcbsla.com](mailto:PCDMStatus@bcbsla.com)**.

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

# Finding Forms on Our 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](http://www.bcbsla.com/providers) >Provider Networks >Join Our Networks

# Easily Complete Forms with DocuSign®

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## 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®

Complete, sign and submit applications and forms to the PCDM Department digitally with **DocuSign**.

This streamlines submissions by reducing the need to print and submit hardcopy documents, allowing for a more direct submission of information to Blue Cross.

It allows you to electronically upload support documentation and even receive reminder alerts to complete submission 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](http://www.bcbsla.com/providers) > Provider Networks > Join Our Networks > Professional Providers/Facilities and Hospitals > Join Our Networks.

**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 application) 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**

**Provider/Signer Information:**  
By clicking the link and using the link, you agree to the terms and conditions of the agreement and accept the terms and conditions of the agreement. Please enter your name and email to begin the signing process.

**Form Completed by:**  
First Name: [Text Field]  
Last Name: [Text Field]  
Email: [Text Field]

**Blue Cross:**  
Please provide information for any other signers needed to this document.  
Provider: [Text Field]  
First Name: [Text Field]  
Last Name: [Text Field]  
Email: [Text Field]

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**

**Clark Welby**  
DEMO - BCBS LA

☒ I agree to use Electronic Records and Signatures.

**CONTINUE** **FINISH LATER** **OTHER ACTIONS**

18/06/2018 01:29 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 & Insurance Company. DocuSign® is an independent company that Blue Cross and Blue Shield of Louisiana use to enable providers to sign and submit provider credentialing and data management forms electronically.

# Easily Complete Forms with DocuSign®

Enter text

FINISH FINISH LATER OTHER ACTIONS ▾

DocuSign Envelope ID: 1A01C5A7-3503-4226-8119-DEA232B827AD

**START**

**Louisiana**

**Provider Update Request Form**

Complete this form to report updated information on your practice to Blue Cross and Blue Shield of Louisiana.

This request applies to: ☒ Individual Provider ☐ Provider Group/Clinic

**CURRENT GENERAL INFORMATION**

Provider Last Name  First Name  Middle Initial

Tax ID Number

Group/Clinic Name

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

Effective Date of Information

Authorized representative completing this form on behalf of a

**AUTHORIZED REPRESENTATIVE**

Contact Phone Number

Contact Email Address

**Submission Information** (form completed by)

Signature of Authorized Representative

Date

February 18, 2021

Navigation tool guides you through fields.

Instructions correspond to requirement of the active field.

Required - Provider National Provider Identifier (NPI) - Please enter 10 numbers only with no special characters.


Tooltips provide information about field requirements.

Red outline indicates a required field.

# Frequently Asked Questions

[Overview](#) [Credentialing Process](#) [Join Our Networks](#) [Update Your Information](#) [Frequently Asked Questions](#)

## Frequently Asked Questions

 [Credentialing Application and Process](#)


**How long does it take to complete the credentialing process?**  
The process can take up to 90 days for completion once BCBSLA receives all the required information.

**How will I know if Blue Cross received my application?**  
Once your application is finalized through DocuSign®, you will receive a confirmation email to notify you the signing process is complete and submitted to Blue Cross for processing.

**What credentialing forms are available online?**  
BCBSLA offers both the [professional provider application](#) and the [facility credentialing application](#) online through DocuSign. They can be found under the Provider Networks >Join Our Networks section of this site.

**Do I need to submit a full credentialing application?**  
If the provider is **NOT** credentialed, please fully complete and submit the professional initial credentialing packet. Facilities should submit the facility initial credentialing packet.

**How do I know what credentialing criteria are required specifically for my specialty type?**  
We have charts online to help you determine what criteria are needed. These charts are based on provider specialty. They are available on this site under Provider Networks >Join Our Networks and look under the appropriate section ([Professional Provider](#) or [Facilities or Hospitals](#)).

**What are the requirements for reimbursement during credentialing?**  
Select provider types that meet specific criteria may be eligible for reimbursement during the credentialing process.  [Click here](#) for full details.

**How do I know if I have been approved for reimbursement during credentialing?**  
A Record Assignment letter will be emailed to the group correspondence email address on file. If you were approved the letter will state that you were approved and the date the reimbursement during credentialing is effective. If you are not approved, your Record Assignment letter will notify you of the reason.

[www.bcbsla.com/providers](http://www.bcbsla.com/providers) >Provider Networks >Join Our Networks  
>Professional Providers/Facilities and Hospitals >Frequently Asked Questions

# **Initial Credentialing for Professional Providers**

# 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)
- Certified Registered Nurse First Assistants (CRNFAs)
- 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)
- Registered Nurse First Assistants (RNFAs)
- Speech-Language Pathologist & Audiologist (SLP)


View the *Credentialing Criteria* for these professional provider types at [www.bcbsla.com/providers](http://www.bcbsla.com/providers) > Provider Networks > Join Our Networks > Professional Providers > Credentialing Process.

# 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.
- 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.

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.

# Required Documentation



## 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](http://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)

☐ I wish to obtain a Blue Cross record only as a NON-PARTICIPATING provider

☐ **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)

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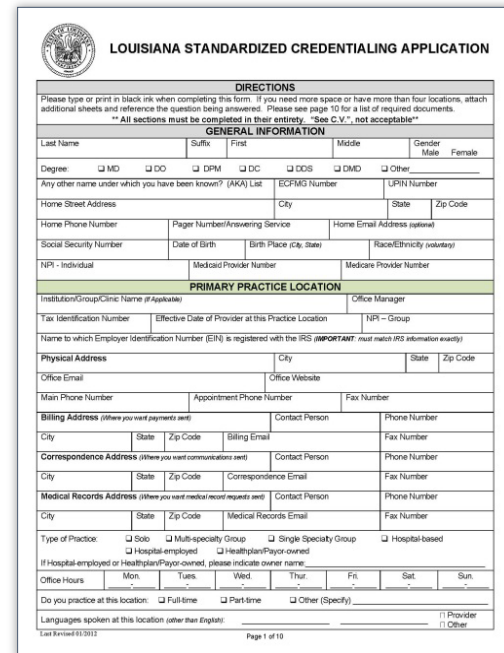
- The Professional (initial) credentialing packet includes a checklist of all required documents.
- To **join our networks through a new contract**, or **joining an existing group**, complete the checklist under "I wish to PARTICIPATE in Blue Cross' network(s)."
- If you **want a provider record only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

# Initial Credentialing Application for Professional Providers

Blue Cross uses the Louisiana Standardized Credentialing Application (LSCA) for initial credentialing.




The image shows the Louisiana Standardized Credentialing Application (LSCA) form. It is a detailed form with multiple sections for professional providers. The form includes a header with the Louisiana State Seal and the title "LOUISIANA STANDARDIZED CREDENTIALING APPLICATION". Below the header is a "DIRECTIONS" section with instructions on how to fill out the form. The main body of the form is divided into several sections: "GENERAL INFORMATION" (including fields for Last Name, First, Middle, Gender, Degree, and Social Security Number), "PRIMARY PRACTICE LOCATION" (including fields for Institution/Group/Clinic Name, Tax Identification Number, and Effective Date of Provider), "BILING ADDRESS" (for billing purposes), "CORRESPONDENCE ADDRESS" (for correspondence), and "MEDICAL RECORDS ADDRESS" (for medical records). The form also includes fields for Office Hours, Languages spoken, and a section for the provider's signature and date. The form is labeled "Page 1 of 10" at the bottom.

Find our credentialing links at [www.bcbsla.com/providers](http://www.bcbsla.com/providers)  
>Provider Networks >Join Our Networks.



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

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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.

In order to be listed in the directory, professional providers must be available to schedule patients' appointments a minimum of 8 hours per week at the location listed.

# **Initial Credentialing for Facilities**

# 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](http://www.bcbsla.com/providers) > Provider Networks > Join Our Networks > Facilities and Hospitals > Credentialing Process.

# New Initial Facility Application

Blue Cross will begin using a new Facility Credentialing Application.

FACILITY CREDENTIALING APPLICATION			
<b>ORGANIZATION SPECIALTY - FIRST PRACTICE LOCATION</b>			
SPECIALTY	<input type="checkbox"/> Alcohol/Drug Rehabilitation Center (CDU) <input type="checkbox"/> Ambulance Services <input type="checkbox"/> Ambulatory Surgical Center <input type="checkbox"/> CDU (Free Standing) <input type="checkbox"/> Charity - Acute Care Hospital <input type="checkbox"/> Comprehensive Outpatient Rehabilitation Facility <input type="checkbox"/> DME <input type="checkbox"/> Emergency Medicine Physicians Group <input type="checkbox"/> Federally Qualified Health Center* <input type="checkbox"/> Home Health Agency <input type="checkbox"/> Hospice <input type="checkbox"/> Hospital	<input type="checkbox"/> Infusion Therapy Provider <input type="checkbox"/> Suite <input type="checkbox"/> Home <input type="checkbox"/> Intensive Outpatient Program <input type="checkbox"/> Laboratory <input type="checkbox"/> Lithotripter Facility <input type="checkbox"/> Long Term Acute Care Facility <input type="checkbox"/> Outpatient Cardiac Catheterization Facility <input type="checkbox"/> Partial Hospitalization Program <input type="checkbox"/> Psychiatric Hospital (Free Standing) <input type="checkbox"/> Psychiatric Hospital <input type="checkbox"/> Radiation Center	<input type="checkbox"/> Radiology (Diagnostic) <input type="checkbox"/> Diagnostic Imaging <input type="checkbox"/> PETS <input type="checkbox"/> Rehabilitation Center (Physical) (Free Standing) <input type="checkbox"/> Renal Dialysis Center <input type="checkbox"/> Residential Treatment Center <input type="checkbox"/> Retail Health Clinic <input type="checkbox"/> Rural Health Clinic* <input type="checkbox"/> Skilled Nursing Facility (Free Standing) <input type="checkbox"/> Sleep Disorder Clinic/Lab <input type="checkbox"/> Specialty Pharmacy <input type="checkbox"/> State Owned Psychiatric Hospital <input type="checkbox"/> Urgent Care Clinic/Walk-in Clinic <input type="checkbox"/> Other: _____
	*Requirements for Federally Qualified Health Center and Rural Health Clinic may vary by health plan.		
	<b>FIRST PRACTICE LOCATION</b>		
	Facility Name: _____		
	Physical Address: _____		
	City: _____ State: _____ ZIP Code: _____		
	Parish/County: _____ Physical Address Email: _____		
	Main Phone: _____ Appointment Phone: _____ Fax: _____		
	Facility Contact: _____ TIN: _____ NPI Number: _____		
	Office Hours: MON TUES WED THURS FRI SAT SUN		
FACILITY	Where should payments be sent?		
	Street Address: _____		
	City: _____ State: _____ ZIP Code: _____		
BILLING	Contact: _____ Phone: _____ Fax: _____ Email: _____		
	Where should communications be sent?		
	Street Address: _____		
CORRESPONDENCE	City: _____ State: _____ ZIP Code: _____		
	Contact: _____ Phone: _____ Fax: _____ Email: _____		
	Where should medical record requests be sent?		
RECORDS	Street Address: _____		
	City: _____ State: _____ ZIP Code: _____		
	Contact: _____ Phone: _____ Fax: _____ Email: _____		
ACCESSIBILITY	Does the office offer handicapped access for:		
	Building? <input type="checkbox"/> Yes <input type="checkbox"/> No Parking? <input type="checkbox"/> Yes <input type="checkbox"/> No Restroom? <input type="checkbox"/> Yes <input type="checkbox"/> No Other: _____		
	Accessible by public transportation:		
	Bus? <input type="checkbox"/> Yes <input type="checkbox"/> No Courier Service? <input type="checkbox"/> Yes <input type="checkbox"/> No Other: _____		
	Offers services for the disabled:		
	Text Telephone (TTY)? <input type="checkbox"/> Yes <input type="checkbox"/> No American Sign Language? <input type="checkbox"/> Yes <input type="checkbox"/> No Mental/Physical Impairment Services? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	Other: _____		
	Does the office meet the American With Disabilities Accessibility (ADA) Requirements? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	Patient Ages: (Please check the age ranges of the client populations you treat)		
	0 to 6 <input type="checkbox"/> 7 - 11 <input type="checkbox"/> 12 - 18 <input type="checkbox"/> 19 - 65 <input type="checkbox"/> Over 65 <input type="checkbox"/> All ages <input type="checkbox"/> Other (Please specify): _____		

# Required Credentialing Forms for Facilities

**As  
Applicable**

The **HDO Information Form** may also require an HDO (Health Delivery Organization) 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

# Required Supporting Documentation for Facilities

## FACILITY CREDENTIALING APPLICATION CHECKLIST

All required documents must be fully completed (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 return the completed checklist and required documents with the Facility Credentialing Application.

- ☐ Include a Facility Credentialing Application.
- ☐ Include applicable Facility Information Form Attachments (required as part of the facility credentialing/recredentialing process for Blue Cross and Blue Shield of Louisiana):
  - ☐ Facility Information Form Attachment A: Ambulance Company
  - ☐ Facility Information Form Attachment B: DME Supplier
  - ☐ Facility Information Form Attachment C: Ambulatory Surgical Center, Hospital, IOP/PHP Psych/CDU, Skilled Nursing Facility, Long Term Acute Care, Rehabilitation Center
  - ☐ Facility Information Form Attachment D: Urgent Care/Walk-in Clinic
  - ☐ Facility Information Form Attachment E: Diagnostic Services
  - ☐ Facility Information Form Attachment F: Retail Health Clinic
  - ☐ Facility Information Form Attachment G: Laboratory
  - ☐ Facility Information Form Attachment H: Outpatient Cath Lab
- ☐ If accredited, include a copy of the current Accreditation Certificate.
- ☐ Include a copy of current state license.
- ☐ Include a W-9 Form.
- ☐ Include an EIN Letter.
- ☐ Include a copy of Malpractice Liability Certificate. DME providers only need to submit Products Liability Insurance Coverage Information.
- ☐ Include a copy of the DEQ license for Radiation Center.
- ☐ Include a copy of the Act 354 Form for Ambulatory Surgical Center and Hospital (required as part of the facility credentialing/recredentialing process for Vantage Health Plan).
- ☐ If facility has 50+ beds, include a copy of the Patient Safety Regulation Attestation for General Acute Hospital, Skilled Nursing Facility, Long Term Acute Care or Physical Rehabilitation Center.
- ☐ Include a copy of the Surety Bond for DME Suppliers (required as part of the facility credentialing/recredentialing process for Vantage Health Plan).
- ☐ Include a copy of the Federal Qualified RHC Letter for Rural Health Clinic (required as part of the facility credentialing/recredentialing process for Vantage Health Plan).

## SUBMIT ALL REQUIRED DOCUMENTS USING ONE OF THE OPTIONS BELOW

Mail:

Vantage Health Plan – Credentialing Dept.  
130 DeSiard Street, Suite 300  
Monroe, LA 71201

Email:

recredentialing@vhpla.com

VH4019, 12/2021, APPROVED



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

# **Recredentialing Process**

**(for both Professional Providers & Facilities)**

# Vantage Health Managing Blue Cross Recredentialing

Use the chart below for the new recredentialing process:

Process initiated by:	Vantage
Form(s) to complete for professional provider recredentialing:	CAQH Application or Louisiana Standardized Credentialing Application (LSCA).
Form(s) to complete for facility reverification:	Facility Credentialing Application, Facility Credentialing Application Checklist and any applicable Facility Information Form Attachments.
Where to submit forms:	To Vantage based on instructions included with recredentialing form.
Verification Process:	Vantage
Who to contact:	Vantage by email: <a href="mailto:recredentialing@vhpla.com">recredentialing@vhpla.com</a> Vantage by phone: (318) 807-4755



# Professional Providers Recredentialing Applications

**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) Last: \_\_\_\_\_ ECFMG Number: \_\_\_\_\_ LPN 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 (optional): \_\_\_\_\_  
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/Physician-owned  
If Hospital-employed or Healthplan/Physician-owned, please indicate owner name: \_\_\_\_\_  
Office Hours: Mon: \_\_\_\_\_ Tues: \_\_\_\_\_ Wed: \_\_\_\_\_ Thurs: \_\_\_\_\_ 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

Page 1 of 10

Vantage accepts the LSCA, as well as the CAHQ application.

**Provider Application**

**INSTRUCTIONS**  
1. Read all instructions carefully before completing this application.  
2. Use a blue or black ink ballpoint pen only. Do not use a pencil or a felt tip pen.  
3. Print clearly and make the letters printed easily legible. Do not use the provided spaces.  
4. Do not enter more than 1 character per box. If necessary, write outside the provided spaces.  
5. Complete all sections that are applicable to you.  
6. Some fields use "codes" to help you easily report information (e.g., schools, languages). Code lists are found on pages 36 - 43.  
NOTE: Fields with asterisks (\*) indicate that a response is required. All other fields will be considered not applicable if left blank.

**SECTION 1 Personal Information and Professional IDs**

**Provider Type**  
Do you practice exclusively within the department setting? (e.g., PATHOLOGIST, ANESTHESIOLOGIST, OR PHYSICIAN, NURSE, NUTRITIONIST, RADIOLOGIST, PHYSICIAN ASSISTANT, ETC.)  
YES ☐ NO ☐

**Name**  
Do not list nicknames or initials, unless they are part of your legal name.  
LAST NAME: \_\_\_\_\_ FIRST NAME: \_\_\_\_\_ MIDDLE NAME: \_\_\_\_\_  
HAVE YOU EVER USED ANOTHER NAME? YES ☐ NO ☐ IF YES, PLEASE LIST ALL OTHER NAMES USED AND THEIR DATES OF USE BELOW.  
OTHER LAST NAME: \_\_\_\_\_ OTHER FIRST NAME: \_\_\_\_\_ OTHER MIDDLE NAME: \_\_\_\_\_  
DATE STARTED USING OTHER NAME: \_\_\_\_\_ DATE STOPPED USING OTHER NAME: \_\_\_\_\_

**General Information**  
Only enter a Foreign National Identification Number if you do not have a SSN. Do not enter National Provider Identification Number here.  
Code list are found on pages 36-43. Enter the appropriate 3-digit code in the space provided.  
GENDER: ☐ MALE ☐ FEMALE DATE OF BIRTH: \_\_\_\_\_  
CITY OF BIRTH: \_\_\_\_\_ STATE OF BIRTH: \_\_\_\_\_ COUNTRY OF BIRTH: \_\_\_\_\_  
SSN: \_\_\_\_\_ FOREIGN NATIONAL IDENTIFICATION NUMBER (FNI): \_\_\_\_\_ PASS COUNTRY OF ISSUE: \_\_\_\_\_  
ENTER ALL NON-ENGLISH LANGUAGES YOU SPEAK: \_\_\_\_\_ LANGUAGE CODE: \_\_\_\_\_ LANGUAGE CODE: \_\_\_\_\_ LANGUAGE CODE: \_\_\_\_\_ LANGUAGE CODE: \_\_\_\_\_

**Home Address**  
NUMBER: \_\_\_\_\_ STREET: \_\_\_\_\_ APT. NUMBER: \_\_\_\_\_  
CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_  
TELEPHONE: \_\_\_\_\_  
NOTE: CASH will use the method of application furnished.  
E-MAIL: \_\_\_\_\_ PREFERRED METHOD OF CONTACT: ☐ E-MAIL ☐ FAX

3076

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Rev. 04-15  
Revised on 11/20/2017

Find our credentialing links at [www.bcbsla.com/providers](http://www.bcbsla.com/providers)  
> Provider Networks > Join Our Networks.

# Required Recredentialing Supporting Documentation for Professional Providers

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The following documents must be submitted with your recredentialing application:

- Copy of state license.
- Copy of DEA registration and CDS license (*as applicable*).
- Copy of Malpractice Liability Certificate (*copy of policy declarations page*).
- Complete the LSCA Attachment A - Location Hours.
- **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.**
- **Rec credentialing packets with incomplete, missing information or submitted incorrectly will be returned.**

# Facility Credentialing Application

We use the Facility Credentialing Application to recredential facilities.

FACILITY CREDENTIALING APPLICATION		
SPECIALTY	ORGANIZATION SPECIALTY - FIRST PRACTICE LOCATION	
	<input type="checkbox"/> Alcohol/Drug Rehabilitation Center (CDU) <input type="checkbox"/> Ambulance Services <input type="checkbox"/> Ambulatory Surgical Center <input type="checkbox"/> CDU (Free Standing) <input type="checkbox"/> Charity - Acute Care Hospital <input type="checkbox"/> Comprehensive Outpatient Rehabilitation Facility <input type="checkbox"/> DME <input type="checkbox"/> Emergency Medicine Physicians Group <input type="checkbox"/> Federally Qualified Health Center* <input type="checkbox"/> Home Health Agency <input type="checkbox"/> Hospice <input type="checkbox"/> Hospital	<input type="checkbox"/> Infusion Therapy Provider <input type="checkbox"/> Suite <input type="checkbox"/> Home <input type="checkbox"/> Intensive Outpatient Program <input type="checkbox"/> Laboratory <input type="checkbox"/> Lithotripter Facility <input type="checkbox"/> Long Term Acute Care Facility <input type="checkbox"/> Outpatient Cardiac Catheterization Facility <input type="checkbox"/> Partial Hospitalization Program <input type="checkbox"/> Psychiatric Hospital (Free Standing) <input type="checkbox"/> Psychiatric Hospital <input type="checkbox"/> Radiation Center
	<input type="checkbox"/> Radiology (Diagnostic) <input type="checkbox"/> Diagnostic Imaging <input type="checkbox"/> PETS <input type="checkbox"/> Rehabilitation Center (Physical) (Free Standing) <input type="checkbox"/> Renal Dialysis Center <input type="checkbox"/> Residential Treatment Center <input type="checkbox"/> Retail Health Clinic <input type="checkbox"/> Rural Health Clinic* <input type="checkbox"/> Skilled Nursing Facility (Free Standing) <input type="checkbox"/> Sleep Disorder Clinic/Lab <input type="checkbox"/> Specialty Pharmacy <input type="checkbox"/> State Owned Psychiatric Hospital <input type="checkbox"/> Urgent Care Clinic/Walk-in Clinic <input type="checkbox"/> Other: _____	
	<small>*Requirements for Federally Qualified Health Center and Rural Health Clinic may vary by health plan.</small>	
	FIRST PRACTICE LOCATION	
	Facility Name: _____ Physical Address: _____ City: _____ State: _____ ZIP Code: _____ Parish/County: _____ Physical Address Email: _____ Main Phone: _____ Appointment Phone: _____ Fax: _____ Facility Contact: _____ TIN: _____ NPI Number: _____ Office Hours: MON TUES WED THURS FRI SAT SUN	
	Where should payments be sent? Street Address: _____ City: _____ State: _____ ZIP Code: _____ Contact: _____ Phone: _____ Fax: _____ Email: _____	
	Where should communications be sent? Street Address: _____ City: _____ State: _____ ZIP Code: _____ Contact: _____ Phone: _____ Fax: _____ Email: _____	
	Where should medical record requests be sent? Street Address: _____ City: _____ State: _____ ZIP Code: _____ Contact: _____ Phone: _____ Fax: _____ Email: _____	
	Does the office offer handicapped access for: Building? <input type="checkbox"/> Yes <input type="checkbox"/> No    Parking? <input type="checkbox"/> Yes <input type="checkbox"/> No    Restroom? <input type="checkbox"/> Yes <input type="checkbox"/> No    Other: _____ Accessible by public transportation: Bus? <input type="checkbox"/> Yes <input type="checkbox"/> No    Courier Service? <input type="checkbox"/> Yes <input type="checkbox"/> No    Other: _____	
Offers services for the disabled: Text Telephone (TTY)? <input type="checkbox"/> Yes <input type="checkbox"/> No    American Sign Language? <input type="checkbox"/> Yes <input type="checkbox"/> No    Mental/Physical Impairment Services? <input type="checkbox"/> Yes <input type="checkbox"/> No Other: _____		
Does the office meet the American With Disabilities Accessibility (ADA) Requirements? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Patient Ages: (Please check the age ranges of the client populations you treat) <input type="checkbox"/> 0 to 6 <input type="checkbox"/> 7 - 11 <input type="checkbox"/> 12 - 18 <input type="checkbox"/> 19 - 65 <input type="checkbox"/> Over 65 <input type="checkbox"/> All ages    Other (Please specify): _____		

# **Other Required Forms**

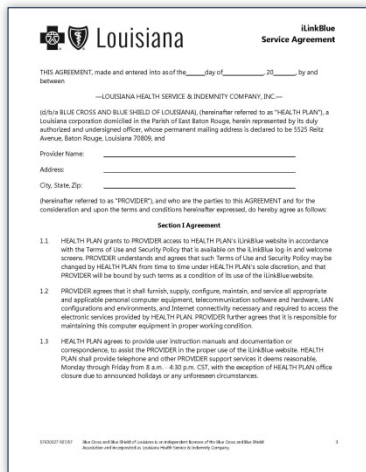
**(for both Professional Providers & Facilities)**

# 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.

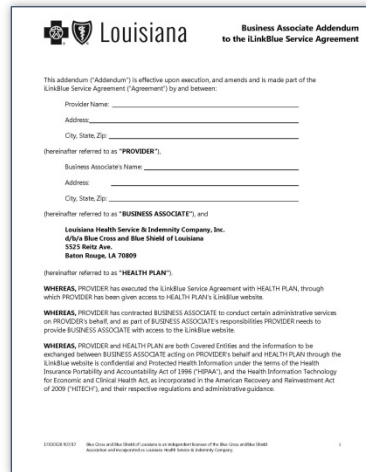
The **iLinkBlue Application Packet** is included in our credentialing packets. These documents are required to access iLinkBlue and become a participating provider.

Below are the four parts:



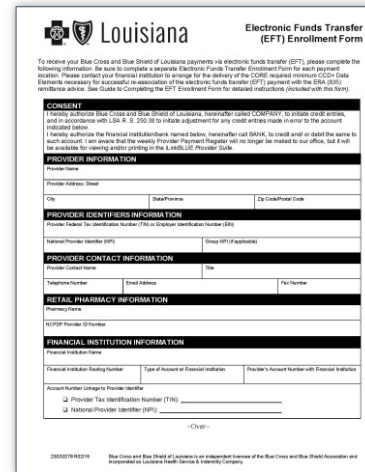
This form is the iLinkBlue Service Agreement. It includes the Louisiana Health Service & Indemnity Company logo and text stating the agreement is made and entered into as of a specific date. It defines the parties as Louisiana Health Service & Indemnity Company, Inc. and the Blue Cross and Blue Shield of Louisiana. The agreement grants the provider access to the iLinkBlue website in accordance with the Terms of Use and Security Policy. It also includes a section for the provider to agree to the terms and conditions of the agreement.

## iLinkBlue Service Agreement



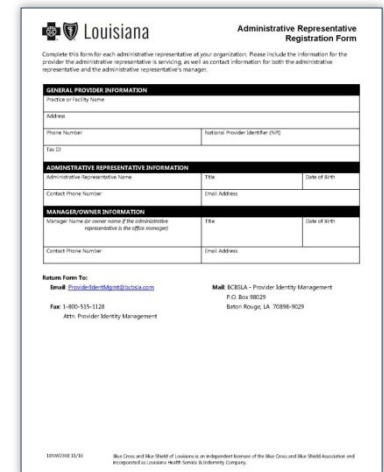
This form is the Business Associate Addendum to the iLinkBlue Service Agreement. It includes the Louisiana Health Service & Indemnity Company logo and text stating the addendum is effective upon execution and amendment. It defines the parties as the Provider and the Business Associate. The addendum outlines the responsibilities of the Business Associate, including the requirement to maintain the confidentiality of the provider's information and to comply with applicable laws and regulations.

## Business Associate Addendum



This form is the Electronic Funds Transfer (EFT) Enrollment Form. It includes the Louisiana Health Service & Indemnity Company logo and text stating the purpose of the form is to enroll the provider in the EFT program. It includes sections for the provider to provide their banking information, including the bank name, account number, and routing number. It also includes a section for the provider to authorize the company to debit their account for payment of claims.

## Electronic Funds Transfer (EFT) Enrollment Form



This form is the Administrative Representative Registration Form. It includes the Louisiana Health Service & Indemnity Company logo and text stating the purpose of the form is to register an administrative representative for the provider. It includes sections for the provider to provide the representative's contact information, including their name, title, phone number, and email address. It also includes a section for the provider to provide the representative's signature and date.


## Administrative Representative Registration Form

The iLinkBlue Application Packet is also available online at [www.bcbsla.com/providers](http://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.


ST000027 08/15/17 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.

1

# 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**").

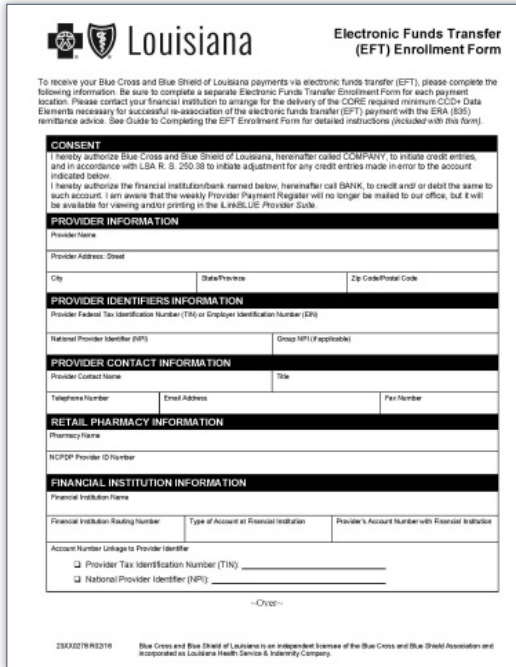
**WHEREAS**, PROVIDER has executed the iLinkBlue Service Agreement with HEALTH PLAN, through which PROVIDER has been given access to HEALTH PLAN's iLinkBlue website.

**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.

EXHIBIT 821/17 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.

# 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 CCDA Data Elements necessary for successful re-association of the electronic funds transfer (EFT) payment with the ERA (S35) remittance advice. See Guide to Completing the EFT Enrollment Form for detailed instructions (provided 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. 255.38 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 Site.

**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) \_\_\_\_\_

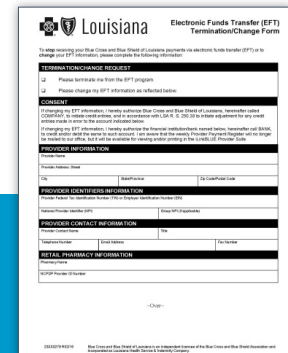
—CH—

23030279 R02316 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](http://www.bcbsla.com/providers) > Resources > Forms.

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



**Louisiana** Electronic Funds Transfer (EFT) Termination/Change Form

To change or update your Blue Cross and Blue Shield of Louisiana payments via electronic funds transfer (EFT) or to change your EFT information, please complete the following information:

**PROVIDER INFORMATION**

1. Please indicate how you are changing your EFT information:

☐ Please indicate how you are changing your EFT information:

☐ Please change to EFT information as indicated below:

**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. 255.38 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 Site.

**PROVIDER INFORMATION**

Provider Name: 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 \_\_\_\_\_

—CH—

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# 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
<small>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.</small>		
<b>GENERAL PROVIDER INFORMATION</b>		
Provider Group or Facility Name		
Address		
Phone Number	Provider Group or Facility National Provider Identifier (NPI)	
Individual Provider Name (if applicable)	Individual Provider NPI (if applicable)	
Tax ID	Is the Behavioral Health Authorizations Application needed?	
<b>ADMINISTRATIVE REPRESENTATIVE INFORMATION</b>		
Administrative Representative Name	Title	Date of Birth
Contact Phone Number	Email Address (This will be used for your unique username)	
Additional Phone Number	Additional Email Address	
<b>MANAGER/OWNER INFORMATION</b>		
Manager/Owner's Name (other than the administrative representative)	Title	Date of Birth
Contact Phone Number	Email Address	
<b>Return Form To:</b> Email: <a href="mailto:PMTTeam@bcbsla.com">PMTTeam@bcbsla.com</a>  Fax: 1-800-515-1128 Attn: Provider Identity Management		
<small>18NW2368 R06/22 Blue Cross and Blue Shield of Louisiana is an independent licensee of the Blue Cross Blue Shield Association.</small>		

The Administrative Representative Registration packet is also available online at [www.bcbsla.com/providers](http://www.bcbsla.com/providers) > Electronic Services > Admin Reps.

# Provider Directory

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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](http://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 8 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.

# Provider Attestation Form

- Due to requirements of the federal Consolidated Appropriation Acts (CAA) 2021, our PCDM Department is sending a Provider Attestation Form every 90 days to all providers listed in our online provider directories to review their information as it appears in our directories.
- If any of your information is not correct, there will be an option within the Provider Attestation Form to complete and return our Provider Update Request Form. This allows us to update the information we publish in our directories.
- The form is emailed in a DocuSign format, prepopulated with the information we have on file. The provider must verify and attest to the accuracy of the information.



Providers who do not complete attestation of their information will be removed from our online provider directories.

**Provider Attestation Form**  
Tax ID No.: \_\_\_\_\_

Use this form to verify the practice location information Blue Cross and Blue Shield of Louisiana has for your organization is correct. The information below is prepopulated from the data Blue Cross has on your current provider record. If any of it is incorrect, you must also complete the Provider Update Request Form in order to remain in our provider directories. Failure to report correct contact information could result in your removal from our online provider directories.

By checking the appropriate box you are attesting that your practice location information is either correct or incorrect.

**Primary Practice Location**

Correct	Incorrect	Provider Last Name	First Name	Middle Initial
	<input type="checkbox"/>	Specialty	Group/Clinic Name	
	<input type="checkbox"/>	Provider National Provider Identifier (NPI)	Group/Clinic National Provider Identifier (NPI)	
	<input type="checkbox"/>	Phone Number	Public Facing Email Address (if available)	
	<input type="checkbox"/>	Address		
	<input type="checkbox"/>	Public Facing Web Address (if available)		

**Second Practice Location**

Correct	Incorrect	Provider Last Name	First Name	Middle Initial
	<input type="checkbox"/>	Specialty	Group/Clinic Name	
	<input type="checkbox"/>	Provider National Provider Identifier (NPI)	Group/Clinic National Provider Identifier (NPI)	
	<input type="checkbox"/>	Phone Number	Public Facing Email Address (if available)	
	<input type="checkbox"/>	Address		
	<input type="checkbox"/>	Public Facing Web Address (if available)		

**Third Practice Location**

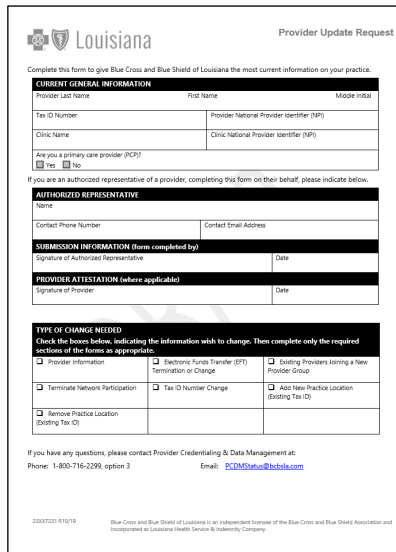
Correct	Incorrect	Provider Last Name	First Name	Middle Initial
	<input type="checkbox"/>	Specialty	Group/Clinic Name	
	<input type="checkbox"/>	Provider National Provider Identifier (NPI)	Group/Clinic National Provider Identifier (NPI)	
	<input type="checkbox"/>	Phone Number	Public Facing Email Address (if available)	
	<input type="checkbox"/>	Address		
	<input type="checkbox"/>	Public Facing Web Address (if available)		

Page 1 of 3  
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# 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.

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

The image shows a 'Provider Update Request' form from Blue Cross and Blue Shield of Louisiana. The form is titled 'Provider Update Request' and includes the Louisiana state logo. It contains several sections: 'CURRENT GENERAL INFORMATION' with fields for Provider Last Name, First Name, Middle Initial, Tax ID Number, Provider National Provider Identifier (NPI), Clinic Name, and Clinic National Provider Identifier (NPI). It also has a checkbox for 'Are you a primary care provider (PCP)?' with 'Yes' and 'No' options. The 'AUTHORIZED REPRESENTATIVE' section has fields for Name, Contact Phone Number, and Contact Email Address. The 'SUBMISSION INFORMATION (Items completed by)' section has fields for Signature of Authorized Representative and Date. The 'PROVIDER ATTESTATION (where applicable)' section has fields for Signature of Provider and Date. The 'TYPE OF CHANGE NEEDED' section has a heading 'Check the boxes below, indicating the information with to change. Then complete only the required sections of the form as appropriate.' and a grid of checkboxes for: 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), and Remove Practice Location (existing Tax ID). At the bottom, it provides contact information: 'If you have any questions, please contact Provider Credentialing & Data Management at: Phone: 1-800-716-2299, option 3 Email: PCDM@bcbsof.com'. The footer includes the date '2/20/2021 10:19' and a disclaimer: '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 & Technology Company.'

- **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.bcbsof.com/providers](http://www.bcbsof.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): <input type="checkbox"/> I am available to see patients at least 16 hours per week on a regular basis. <input type="checkbox"/> I see patients here at least one day per month, but less than one day per week on a regular basis. <input type="checkbox"/> I cover or fill-in for colleagues within the same medical group on an as-needed basis only. <input type="checkbox"/> I read tests or provide other services but do not see patients at this location. <input type="checkbox"/> I do not practice here, but this location is within the medical group with which I am employed.							
<b>SECOND PHYSICAL ADDRESS (if necessary)</b>							
Physical Address							
City, State and ZIP Code					Phone Number		Fax Number
Email Address							
Type of Practice: <input type="checkbox"/> No change <input type="checkbox"/> Solo <input type="checkbox"/> Multi-specialty Group <input type="checkbox"/> Single Specialty Group <input type="checkbox"/> Hospital-based <input type="checkbox"/> Hospital-employed <input type="checkbox"/> Healthplan/Payor-owned							
Accepting New Patients <input type="checkbox"/> New <input type="checkbox"/> Existing Only <input type="checkbox"/> Other: _____				Age Range of Patients (check all that apply) <input type="checkbox"/> 0-6 years <input type="checkbox"/> 7-11 years <input type="checkbox"/> 12-18 years <input type="checkbox"/> 19-65 years <input type="checkbox"/> Over 65 <input type="checkbox"/> All Ages <input type="checkbox"/> Other: _____			
Office Hours	Mon. ____-____	Tues. ____-____	Wed. ____-____	Thurs. ____-____	Fri. ____-____	Sat. ____-____	Sun. ____-____
Practice Hours (available appointment hours)							
Mon. ____-____	Tues. ____-____	Wed. ____-____	Thurs. ____-____	Fri. ____-____	Sat. ____-____	Sun. ____-____	
For this practice location (please select at least one option): <input type="checkbox"/> I am available to see patients at least 16 hours per week on a regular basis. <input type="checkbox"/> I see patients here at least one day per month, but less than one day per week on a regular basis. <input type="checkbox"/> I cover or fill-in for colleagues within the same medical group on an as-needed basis only. <input type="checkbox"/> I read tests or provide other services but do not see patients at this location. <input type="checkbox"/> I do not practice here, but this location is within the medical group with which I am employed.							
<b>CHECKLIST</b>							
Before returning this form to Blue Cross, please ensure the following: <input type="checkbox"/> A copy of the Malpractice Liability Insurance Certificate is attached <input type="checkbox"/> 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.							

# Provider Credentialing & Data Management (PCDM)

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Provider Network Setup, Credentialing & Demographic Change

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**Mallory Trant**, Provider Information Supervisor (Credentialing)  
[mallory.trant@bcbsla.com](mailto:mallory.trant@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](mailto:PCDMStatus@bcbsla.com) or by calling 1-800-716-2299, option 2.

## ADDRESSING YOUR

# FEEDBACK

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](mailto:provider.relations@bcbsla.com).

