

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.

CREDENTIALING, CONTRACTING, RE-CREDENTIALING & DATA MANAGEMENT

November 2024
Blue Cross and Blue Shield of Louisiana



Presented by:

Melonie Martin
provider relations representative

Blue Cross and Blue Shield of Louisiana is an independent licensee of the Blue Cross Blue Shield Association.

DocuSign® is an independent company that Blue Cross and Blue Shield of Louisiana uses to enable providers to sign and submit provider credentialing and data management forms electronically.

WELCOME!

- ✓ Today's presentation will take you on a journey through the **credentialing** and **recredentialing** processes.
- ✓ We will also explain the network **contracting** process.
- ✓ We will show you how to update and **manage the data** Louisiana Blue has on your provider record.



THE BASICS

Credentialing Is Required for Network Participation



Louisiana Blue credentials all practitioners and facilities that participate in our networks.



We partner with **symplrCVO** to conduct credentialing verification processes for our commercial and Blue adVantage networks.

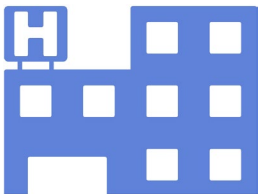
THE BASICS

We credential
professional



&

facility providers



Credentialing is Required for Network Participation

- Since 1996, Louisiana Blue fully credentials providers who apply for network participation.
- Our credentialing program is accredited by the Utilization Review Accreditation Commission (URAC).
- Providers must meet certain criteria as regulated by our accreditation body and the Blue Cross Blue Shield Association.

THE BASICS

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

Network-participating provider record



Contract on File
&
Provider **IS**
credentialed

Non-participating provider record *(for filing claims only)*



No Contract
&
Provider **IS NOT**
credentialed

What is a Participating Provider?

- Provider who has entered into a contractual agreement with Louisiana Blue 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 Louisiana Blue 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.lablue.com).



What is a Non-participating Provider?

- Provider who has chosen not to sign a network agreement with Louisiana Blue.
- 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 Louisiana Blue with the exception of services covered under the No Surprises Act.

- In most situations, Louisiana Blue 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.

Applying for Credentialing

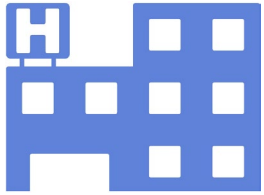


Professional Provider Network Availability

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 (CRNFA)
- Clinical Nurse Specialist (CNS)
- 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 Midwife
- 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 (RNFA)
- Speech-Language Pathologist & Audiologist (SLP)

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

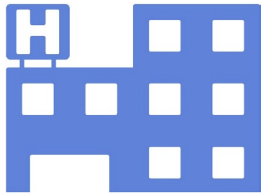


Facility Network Availability

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

- Ambulance Service
- Ambulatory Surgical Center
- Birthing Centers
- Cardiac Cath Lab (Outpatient)
- Diagnostic Services (including CMS Independent Diagnostic Testing Facilities)
- 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 types at www.lablue.com/providers >Network Enrollment >Join Our Networks >Facilities and Hospitals >Credentialing Process.



HOSPITAL-BASED PROVIDERS

A hospital/facility-based provider includes:

- Providers who **only** see patients as a result of their being admitted or directed to the hospital.
- Providers who **only** read test results or perform services in a facility, for which a member cannot directly make an appointment.
- Medical staff.

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 they have patients referred directly to them from another physician or organization or if the member can make an appointment with the physician.



TELEHEALTH ONLY PROVIDERS

Our credentialing policy includes guidance for the provision of telehealth services to our members **WHEN:**

- **Louisiana-based, in-network provider**

- Must be in process of or have completed credentialing/contracting to participate in our network.
- Must be employed or affiliated with a physical practice located in Louisiana.
 - Behavioral health telehealth-only providers are not required to be employed or affiliated with a physical practice located in Louisiana but **must be located and licensed in Louisiana.**

- **Out-of-state provider with Louisiana-based practice**

- Must be employed or affiliated with a Louisiana-based group or entity.
- Must have a Louisiana State license as required for their specialty.
- If not licensed in the state of Louisiana, then a Telehealth Permit issued by the Louisiana Board of Medical Examiners (LSBME) is required (includes the condition of maintaining affiliation with a Louisiana based practice or entity).

- **Out-of-state provider without Louisiana-based practice affiliations**

- Must be credentialed/contracted with another Blue Plan.
- Can be individually credentialed/contracted or part of a group or entity that is credentialed/contracted with the out-of-state Blue Plan.
- Claims filing is based on the providers physical location when rendering the telehealth service.

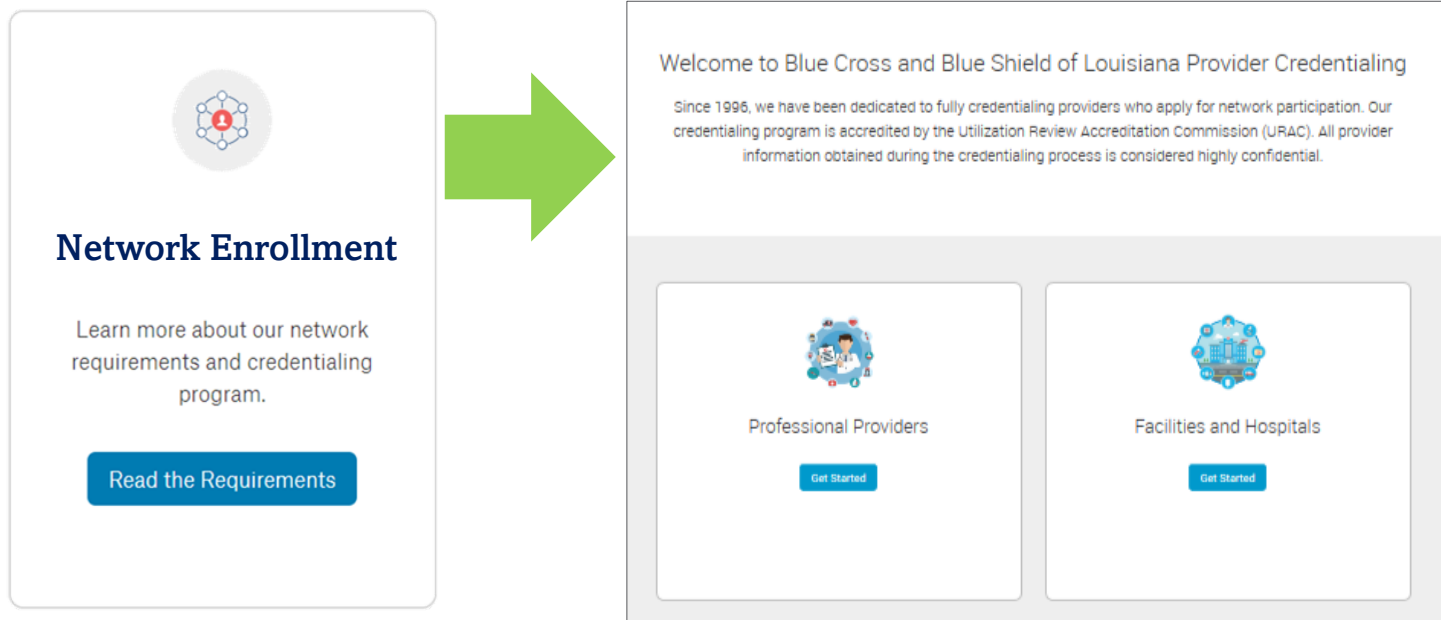
- **National telehealth solution/vendor**

- A national telehealth solution contracts directly with Louisiana Blue to offer our members telehealth services accessible in the home plan region and outside of it to ensure access while members are out of their home plan area.

THE PAPERWORK

You **MUST** complete and submit documentation to start the process for credentialing **OR** to obtain a provider record.

Applications are available online at www.lablue.com/providers.



Choose **Network Enrollment**, then **Join Our Networks** page then, select **Professional Providers** or **Facilities and Hospitals** to find credentialing packets.



THE PAPERWORK for professional providers

[Overview](#) [Credentialing Process](#) [Join Our Networks](#) [Update Your Information](#) [FAQs](#)

Join Our Networks

Your request can take up to 90 days to process once all required information has been received. The BCBSLA Welcome to the Network notification letter will notify you of next steps and your network participation effective date shall be the effective date indicated on the signature page of your provider agreement. Louisiana Blue does not backdate network participation. Any claims submitted prior to network participation will process as out-of-network. When a claim is processed as out-of-network, payment for services may go to the member not to the provider.

Applying for network participation has been made easy. Our online applications can now be completed, signed and submitted digitally with **DocuSign**. Each packet includes a checklist of all required documents. Please follow that checklist to ensure all information is included with the submission of your application. Louisiana Blue uses the LSCA for both credentialing and recredentialing applications.

[Professional Initial Credentialing Packet](#)

[Professional CAQH Credentialing Packet](#)



The Professional (initial) credentialing packets 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.”



THE PAPERWORK for professional providers

Professional Initial Credentialing Packet

Professional CAQH Credentialing Packet

Louisiana

You may choose to participate in our networks under a new provider agreement or join a provider group with an existing provider record as a non-participating provider for the purpose of filing claims. Please complete the appropriate check fully completed with a signature and date. Requests that are incomplete or missing information will be returned and the required information is received. If you have any questions about our credentialing requirements, please visit our 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 LinkBlue Service Agreement

Complete the Business Associate Addendum to the LinkBlue Service Agreement

Complete the Electronic Funds Transfer (EFT) Enrollment Form

Enclose a cancelled 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). Collaborating physician must participate in the same network as the applicant.

Enclose a copy of Malpractice Liability Certificate (copy of policy declarations page)

18NW2513 R12.02

LOUISIANA STANDARDIZED CREDENTIALING APPLICATION

DIRECTIONS
Please type or print in black ink when completing this form. Do not use more space or have more than four locations, which additional sheets are necessary to reference the greatest length of information. This form must be typed in black ink. All sections must be completed in their entirety. "See C.V." not acceptable.

GENERAL INFORMATION

Any other name under which you have been known? (MAY) Last: _____ Middle: _____ Gender: _____ Female

Last Name: _____ Suffix: _____ First: _____ Middle: _____ Gender: _____ Female

Home Phone Number: _____ Day: _____ State: _____ Zip Code: _____

Home Email Address: _____

Medical Provider Number: _____

Medical License Number: _____

Medical Board Number: _____

PRIMARY PRACTICE LOCATION

Healthcare Organization Name (as applicable): _____ Office Manager: _____

Facility Identification Number: _____ Effective Date of Provider at this Practice Location: _____ NPI - Group: _____

Name to which Employer Identification Number (EIN) is registered with the IRS (separate EIN used under EIN umbrella entity): _____

Physical Address: _____ City: _____ State: _____ Zip Code: _____

Office Email: _____

Appointment Phone Number: _____ Fax Number: _____

Billing Address (different from main address): _____ Contact Person: _____ Phone Number: _____

City: _____ State: _____ Zip Code: _____ Billing Email: _____

Correspondence Address (different from main address): _____ Contact Person: _____ Phone Number: _____

City: _____ State: _____ Zip Code: _____ Correspondence Email: _____

Medical Records Address (different from main address): _____ Contact Person: _____ Phone Number: _____

City: _____ State: _____ Zip Code: _____ Medical Records Email: _____

Type of Practice: _____ Solely Proprietorship Single Member LLC Partnership Health Plan/Payer-owned Hospital-employed Health Plan/Payer-owned Other (specify): _____

Office Hours: Mon. _____ Tues. _____ Wed. _____ Thurs. _____ Fri. _____ Sat. _____ Sun. _____

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

Language spoken at this location other than English: _____

18NW2513 R12.02 Page 1 of 3

Louisiana

You may choose to participate in our networks under a new provider agreement or join a provider group with an existing provider record as a non-participating provider for the purpose of filing claims. Please complete the fully completed with a signature and date. Requests that are incomplete or missing information will be returned and the required information is received. If you have any questions about our credentialing requirements, please visit our 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 and attach to the Council for Affordable Quality Healthcare (CAQH) Credentialing Application

Attachment A - Location Hours (Note: Only list the locations that you wish to list to your RSCGA provider record)

Complete the Business Associate Addendum to the LinkBlue Service Agreement

Complete the Electronic Funds Transfer (EFT) Enrollment Form

Enclose a cancelled 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). Collaborating physician must participate in the same network as the applicant.

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Provider Application

SECTION 1

Provider Type

General Information

Home Address

3076

Page 01

Important CAQH Requirements:

- Attention must be current and active (updated and attached to every four months)
- Documents must be current and active.

- Complete checklist
- Submit all the indicated documents.
- Incomplete credentialing packets (missing information or submitted incorrectly) may be returned. A letter is sent advising of the missing information and how to resubmit.

- Complete checklist
- Provide your CAQH ID



THE PAPERWORK for professional providers

The **iLinkBlue Application Packet** is part of our credentialing packet and must be completed.

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.—

8819 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 70806, 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 Agreement

- 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 screen. 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.
- 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.
- 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.

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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.
419 1/2 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.

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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 return (CCO) Code Elements necessary for automatic re-authorization of the electronic funds transfer (EFT) payment with the BNA (BNA 030) residence address. See Guide to Completing the EFT Enrollment Form for detailed instructions (available with this form).

CONSENT

I hereby authorize Blue Cross and Blue Shield of Louisiana, hereinafter called "COMPANY", to initiate credit entries and debit payments with Visa, R. S. 209:38 to initiate adjustment for any credit entries made in error to the account I have listed below.

I hereby authorize the financial institution/bank named below, hereinafter called "BANK", to credit and/or debit the same to each account. I am aware that the weekly Electronic Payment Charges will no longer be related to my office, but I will be available for viewing printout printing in the iLinkBlue Provider Guide.

PROVIDER INFORMATION

Provider Name: _____
Provider Address: Street _____
City _____ State _____ Zip _____
Title _____ Bank Position _____ E/Fr Cash/Printer Cook _____

PROVIDER IDENTIFIERS INFORMATION

Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN) _____
National Provider Identifier (NPI) _____ Group (NPI) Organization _____

PROVIDER CONTACT INFORMATION

Phone Number _____ Fax _____
Telephone Number _____ Email Address _____ Fax Number _____

RETAIL/PHARMACY INFORMATION

Pharmacy Name _____
NCPDP Provider ID Number _____

FINANCIAL INSTITUTION INFORMATION

Financial Institution Routing Number _____ Type of Account at Financial Institution _____ Provider's Account Number with Financial Institution _____
Account Number (unique to Provider Identity) _____
① Provider Tax Identification Number (TIN) _____
② National Provider Identifier (NPI) _____

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Electronic Funds Transfer (EFT) Enrollment Form

LOUISIANA BLUE **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

Provider Organization or Facility Name _____
Address _____
Phone Number _____ Provider Group/Class or Facility NPI _____
Individual Provider Name (if applicable) _____ Individual Provider NPI (if applicable) _____
Tax Identification Number _____ Is the Behavioral Health Authorization Application needed? _____

ADMINISTRATIVE REPRESENTATIVE INFORMATION

Administrative Representative Name _____ Title _____ Date of Birth _____
Contact Home Number _____ Email Address (this will be used for your unique claimant) _____
Additional Home Number _____ Additional Email Address _____

MANAGER/OWNER INFORMATION

Manager/Owner Name (must be the administrative representative) _____ Title _____ Date of Birth _____
Contact Home Number _____ Email Address _____

Returns Form To: _____
Email: ilinkblue@lablue.com
Fax: 1-800-515-1129
Attn: Provider Identity Management

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Administrative Representative Registration Form

iLinkBlue is our secure online provider tool. It is your source for eligibility, benefits, claims filing, claims research, payment queries, authorization requests and more.

www.lablue.com/ilinkblue



THE PAPERWORK for facilities

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

Join Our Network

Your request can take up to 90 days to process once all required information has been received. The BCBSLA Welcome to the Network notification letter will notify you of next steps and your network participation effective date shall be the effective date indicated on the signature page of your provider agreement. BCBSLA does not backdate network participation. Any claims submitted prior to network participation will process as out-of-network. When a claim is processed as out-of-network, payment for services may go to the member not to the provider.

Applying for network participation has been made easy. Our online Facility Initial Credentialing packet can now be completed, signed and submitted digitally with **DocuSign**. Each packet includes a checklist of all required documents. Please follow that checklist to ensure all information is included with the submission of your application.

Facility Initial Credentialing Packet

Some of the required credentialing supporting documentation for Facilities and Hospitals includes:

- Health Delivery Organization (HDO) Form
- HDO Attachment, as applicable
- State License
- Malpractice Liability Certificate (copy of declarations page)

Network facilities and hospitals are reverified every three years from their last credentialing acceptance date. Blue Cross sends reverification packets directly to facilities and hospitals based on the correspondence information on file.



The Facility Initial Credentialing Packet includes a checklist of all required documents needed for credentialing.




THE PAPERWORK for facilities

Facility Initial Credentialing Packet

The **Checklist** must be completed.

- Submit all indicated documents.
- Incomplete credentialing packets (missing information or submitted incorrectly) may be returned. A letter is sent advising of the missing information and how to resubmit.

This Packet is in **DocuSign®** to be completed, signed and submitted digitally.



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)

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

Submit all required documents using one of the options below:

mail: BCBSLA - PCDM P.O. Box 98029 Baton Rouge, LA 70898-9029	email: network.administration@bcbsla.com fax: (225) 297-2750 Attention: PCDM
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18NW2512 R07/19
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THE PAPERWORK for facilities

Louisiana Blue uses the **Facility Credentialing Application** for initial credentialing.

There are attachment forms included with the main credentialing form. Facilities should complete only those that apply.

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 <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 <input type="checkbox"/>		
Accessible by public transportation:	Bus <input type="checkbox"/> Yes <input type="checkbox"/> No	Courier Service <input type="checkbox"/> Yes <input type="checkbox"/> No	Other <input type="checkbox"/>
Office services for the disabled:	Text Telephony (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 <input type="checkbox"/>		
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 to 11 <input type="checkbox"/> 12 to 18 <input type="checkbox"/> 19 to 65 <input type="checkbox"/> Over 65 <input type="checkbox"/> All Ages			
<input type="checkbox"/> Other (please specify):			

23X06077 03/23 1 of 6
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- Attachment A – Ambulance
- Attachment B – DME Supplier
- Attachment C – ASC, Hospital, IOP, PHP, Psych, CDU, SNF, LTAC, Rehab
- Attachment D – Urgent Care, Walk-in Clinic
- Attachment E – Diagnostic Services
- Attachment F – Retail Health Clinic
- Attachment G – Laboratory
- Attachment H – Outpatient Cath Lab



THE PAPERWORK for facilities

The **iLinkBlue Application Packet** is part of our credentialing packet and must be completed.

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.—

8819 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 70806, 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 1 Agreement

- 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 screen. 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.
- 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.
- 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.

1500001 03/17 Blue Cross and Blue Shield of Louisiana is an independent licensee of the Blue Cross and Blue Shield Association and is not affiliated with or endorsed by the Blue Cross and Blue Shield Association.

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.
4819 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.

1500001 03/17 Blue Cross and Blue Shield of Louisiana is an independent licensee of the Blue Cross and Blue Shield Association and is not affiliated with or endorsed by the Blue Cross and Blue Shield Association.

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 return CC/D-Link Elements necessary for automatic re-authorization of the electronic funds transfer (EFT) payment with the BNA (BNA 0302) residence address. See Guide to Completing the EFT Enrollment Form for detailed instructions (available with this form).

CONSENT

I hereby authorize Blue Cross and Blue Shield of Louisiana, hereinafter called "COMPANY", to initiate credit entries and debit payments with Visa, R. S. 209:38 to initiate adjustment for any credit entries made in error to the account I have listed.

I hereby authorize the financial institution/bank named below, hereinafter called "BANK", to credit and/or debit the same to each account. I am aware that the weekly Electronic Payment Charges will no longer be related to my office, but I will be available for viewing printout printing in the iLinkBlue Provider Guide.

PROVIDER INFORMATION

Provider Name: _____
Provider Address: Street _____
City _____ State _____ Zip _____
EFT Check/Printer Cook _____

PROVIDER IDENTIFIERS INFORMATION

Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN) _____
National Provider Identifier (NPI) _____
Group (NPI) Organization _____

PROVIDER CONTACT INFORMATION

Phone Number _____ Fax _____
E-mail Address _____ Fax Number _____

RETAIL/PHARMACY INFORMATION

Pharmacy Name _____
NCPDP Provider ID Number _____

FINANCIAL INSTITUTION INFORMATION

Financial Institution Routing Number _____ Type of Account at Financial Institution _____ Provider's Account Number with Financial Institution _____
Account Number (unique to Provider Identity) _____
① Provider Tax Identification Number (TIN) _____
② National Provider Identifier (NPI) _____

1500001 03/17 Blue Cross and Blue Shield of Louisiana is an independent licensee of the Blue Cross and Blue Shield Association and is not affiliated with or endorsed by the Blue Cross and Blue Shield Association.

Electronic Funds Transfer (EFT) Enrollment Form

LOUISIANA BLUE **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

Provider (Organizational) Facility Name _____
Address _____
Phone Number _____ Provider Group/Office or Facility NPI _____
Individual Provider Name (if applicable) _____ Individual Provider NPI (if applicable) _____
Tax Identification Number _____ Is the Behavioral Health Authorization Application needed? _____

ADMINISTRATIVE REPRESENTATIVE INFORMATION

Administrative Representative Name _____ Yes _____ Date of Birth _____
Contact Home Number _____ Email Address (this will be used for your unique claimant) _____
Additional Home Number _____ Additional Email Address _____

MANAGER/OWNER INFORMATION

Manager/Owner Name (Name of the Business Representative) _____ Yes _____ Date of Birth _____
Contact Home Number _____ Email Address _____

Returns Form To: _____
Email: ilinkblue@lablue.com
Fax: 1-800-515-1129
Attn: Provider Identity Management

1500001 03/14 Blue Cross and Blue Shield of Louisiana is an independent licensee of the Blue Cross and Blue Shield Association.

Administrative Representative Registration Form

iLinkBlue is our secure online provider tool. It is your source for eligibility, benefits, claims filing, claims research, payment queries, authorization requests and more.

www.lablue.com/ilinkblue

Let's Get Credentialed

THE CREDENTIALING PROCESS

- Providers will remain non-participating in our networks until a signed agreement is received by our contracting department.
- The credentialing committee approves credentialing twice per month.
- Network providers are recredentialed every three years from their last credentialing acceptance date.



To inquire about the status of your initial credentialing application, you may send an email to PCDMstatus@lablue.com.



VERIFYING YOUR INFORMATION



We partner with **symplrCVO**, to assist with the primary source verification of our credentialing and recredentialing applications.

Professional providers in the credentialing and recredentialing process may be directly contacted by symplrCVO to verify application details and supporting documentation. This does not apply to facilities.



symplrCVO will make three attempts to contact the provider. If unsuccessful, the credentialing process is stopped, and the application is rejected. For providers in the recredentialing process, network participation may be terminated.



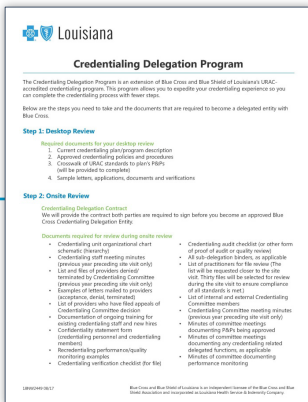
If you have questions about this process, you may email our Provider Relations Department at provider.relations@lablue.com.

CREDENTIALING DELEGATION PROGRAM

- It is an extension of our accredited credentialing program and is available to groups **with 50 or more practitioners.**
- An approved delegation entity essentially credentials its own providers and sends the information to Louisiana Blue to create their provider records.
- This program allows you to expedite your credentialing experience so you can complete the Louisiana Blue credentialing process with fewer steps.
- 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 Louisiana Blue system.



If you have any questions about the Credentialing Delegation Program, please email credentialing.delegation@lablue.com.



The *Credentialing Delegation Program* guide explains the steps network provider groups must take, and the documents required to become a delegated entity. It is sent to providers requesting to join the program.

REIMBURSEMENT DURING CREDENTIALING

Reimbursement During Credentialing applies to all professional provider types, when criteria are met.

Reimbursement During Credentialing will be granted to all professional providers **joining an existing contracted provider group**. That contracted group must have the **same provider type contract** on file with Louisiana Blue. This allows for in-network reimbursement on submitted claims during the credentialing process. Once the application has passed the pre-screening process, reimbursement during credentialing is backdated one month prior to the date of application receipt or the clinic start date, whichever is more recent.

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, send an email to **PCDMstatus@lablue.com**.

EXPEDITED PROCESSING

Expedited processing applies to a limited group of professional providers only. In most cases, this applies to practitioners with admitting privileges or admitting arrangements.

Louisiana law allows professional providers a 30-day expedited application processing. To be eligible for expedited processing, providers must meet the following criteria:

- Providers who are:
 - Already credentialed with Louisiana Blue and are joining a new group, or
 - Are not yet credentialed but are joining a provider group that already has an executed group agreement on file with Louisiana Blue for the same provider type.



Example: An NP applying for network participation must be joining a provider group that already has an executed allied health agreement on file with Louisiana Blue.

- Physicians must have admitting privileges to a network hospital or an approved exception.
- When applicable, provider must list their admitting privileges information in the hospital affiliations section on the appropriate credentialing application.
- Louisiana Blue credentialing policy allows certain eligible providers to have an arrangement with a hospitalist group to admit their patients in lieu of their own hospital privileges. A copy of the arrangement must be submitted with the credentialing application.
- Agree to hold our members harmless for payments above the allowable amount.

EXAMPLE LETTER TO LOUISIANA BLUE

To request expedited processing, include the following with the initial credentialing application:

- Letter asking Louisiana Blue to invoke the expedited process.
- The letter must:
 1. Include your agreement to hold our members harmless for payments above the allowable amount.
 2. Identify the provider group name.
 3. Be on company letterhead and signed by the provider or an authorized representative. An electronic signature is acceptable.
- When applicable, signed admitting privileges agreement to a network hospital.

Sample Letter

{Date}

Dear Louisiana Blue:

In accordance with the Louisiana law extending certain requirements for credentialing of healthcare providers, please accept this written request for expedited processing for **{provider's name}** as a new provider at **{provider's group name}** at our group contract rate and with in-network benefits. **{Provider's group name}** agrees that all contract provisions, including holding covered members harmless for charges beyond the Louisiana Blue allowable amount, and the member's cost share amount (deductible, coinsurance and/or copayment, as applicable) will apply to the new provider.

{Signature of the provider}

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 Louisiana Blue.
- Includes multiple Louisiana Blue employees from Medical Management and Network Development & Contracting Departments.





EFFECTIVE DATES

For non-participating providers (requesting a provider record only), Louisiana Blue allows an effective date up to two years back for providers who want a provider record only for filing claims.

For participating providers, Louisiana Blue 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.	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 or the clinic start date, whichever is more recent. OR If you are not eligible for reimbursement during credentialing, then it is the approved date by the Credentialing Committee AND the execution of your network agreement.	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.

Signing the Contract

NETWORK AGREEMENT (the final paperwork)

Once the credentialing process is completed, the next step in the process is to ensure the provider has a signed network agreement.



Our Provider Contracting representatives will work with the provider for the appropriate networks available for participation. Providers remain non-participating in our networks until a signed agreement is received by our Contracting Department.



The signed network agreement will include the effective date of network participation, which will be the date of approval from the Credentialing Committee.



If you have any questions about the contracting process, send an email to provider.contracting@lablue.com.

THE NETWORK AGREEMENT the final paperwork



Professional providers who are new to the network may not always be required to sign a contract.

A new agreement **IS REQUIRED** for:

- Newly credentialed solo practitioners
- Newly credentialed providers joining a group not currently participating with Louisiana Blue
- Newly credentialed providers joining a participating group that does not have an agreement on file for the provider type:

Example 1: a nurse practitioner (NP) joins a participating physician group (only has a physician agreement on file). The group must sign an allied agreement to cover the NP.

Example 2: a physician joins a participating allied group (only has an allied agreement on file). The group must sign a physician agreement.

- Existing network providers asking to join a different network
- Some participating providers, groups or facilities changing Tax ID number (TIN).

THE NETWORK AGREEMENT **the final paperwork**



Professional providers who are new to the network may not always be required to sign a contract.

A new agreement **IS NOT REQUIRED** when:

- A newly credentialed physician and/or allied provider joins a participating group that already has the applicable physician and/or allied agreement on file.
- A newly credentialed physician and/or allied provider is joining a participating group through the Louisiana Blue Delegated Credentialing Agreement program, **and** that group has the applicable physician and/or allied agreement on file.

Staying in the Network

RECREREDENTIALING

The Credentialing Committee reviews all recredentialing applications.

Network providers must be approved through our **rec credentialing** process **every three years** (or within 1 year in some cases) from the last credentialing acceptance date. Louisiana Blue is partnered with symplrCVO to rec credential our network providers. Louisiana Blue sends* rec credentialing applications to providers approximately 6 months prior to their rec credentialing due date. Instructions are included on how to return completed forms. Louisiana Blue or symplrCVO will complete the verification process.

Required applications:



Professional providers: Louisiana Standardized Credentialing Application (LSCA) or CAQH Application



Facilities: Facility Credentialing Application and any applicable application attachments



If you have questions during the process, you may email rec credentialing@lablue.com or call (318) 807-4755.

RECREREDENTIALING



Professional

Providers due for recredentialing are sent an email (correspondence email on file) six months prior to recredentialing due date.

The email provides:

- A link to the LSCA, if using CAQH you can provide your CAQH ID
- A checklist of required supporting documentation
- Instructions on how to complete and return the application

The following forms for recredentialing are accepted.

LOUISIANA STANDARDIZED CREDENTIALING APPLICATION

OR

Provider Application

The image shows two forms side-by-side. The left form is the 'LOUISIANA STANDARDIZED CREDENTIALING APPLICATION' with sections for 'DIRECTIONS', 'GENERAL INFORMATION', and 'PRIMARY PRACTICE LOCATION'. The right form is the 'Provider Application' with sections for 'GENERAL INFORMATION', 'PERSONAL INFORMATION AND PROFESSIONAL IDs', and 'HOME ADDRESS'. Both forms contain various fields for personal and professional details, including names, addresses, phone numbers, and dates.

If information is missing from submitted recredentialing application, the provider is then contacted by a recredentialing specialist with a deadline to return the needed information. If not received timely, then provider may be terminated from the network. Accreditation standards prohibit us from listing providers as in-network past their recredentialing due date.

RECREREDENTIALING

The following forms for recredentialing are accepted.



Facility

Facilities due for recredentialing are sent an email (correspondence email on file) six months prior to recredentialing due date.

The email provides:

- A link to the Facility Credentialing Application
- A checklist of required supporting documentation
- Instructions on how to complete and return the application

ORGANIZATION SPECIALTY - FIRST PRACTICE LOCATION

Alcohol/Drug Rehabilitation Center (CDU) Infusion Therapy Provider Radiology (Diagnostic)

Ambulance Services Suite Diagnostic Imaging

Ambulatory Surgical Center Home PE/PT

CDU (Free Standing) Intensive Outpatient Program Rehabilitation Center (Physical) (Free Standing)

Charity - Acute Care Hospital Laboratory Renal Dialysis Center

Comprehensive Outpatient Rehabilitation Facility Lithotripter Facility Residential Treatment Center

DME Long Term Acute Care Facility Retail Health Clinic

Emergency Medicine Physicians Group Outpatient Cardiac Catheterization Facility Rural Health Clinic*

Federally Qualified Health Center* Partial Hospitalization Program Skilled Nursing Facility (Free Standing)

Home Health Agency Psychiatric Hospital (Free Standing) Sleep Disorder Clinic/Lab

Hospital Hospital Radiation Center Specialty Pharmacy

Hospital Hospital State Owned Psychiatric Hospital

Hospital Hospital Urgent Care Clinic/Walk-In Clinic

Hospital Hospital Other: _____

*Requirements for Federally Qualified Health Center and Rural Health Clinic may vary by health plan.

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

BLUE

Street Address: _____

City: _____ State: _____ ZIP Code: _____

Contact: _____ Phone: _____ Fax: _____ Email: _____

CORRESPONDENCE

Street Address: _____

City: _____ State: _____ ZIP Code: _____

Contact: _____ Phone: _____ Fax: _____ Email: _____

RECORDS

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: _____

ACCESSIBILITY

Offers services for the disabled:

Toll Telephone (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 population you treat)

0 to 6 7 - 11 12 - 18 19 - 65 Over 65 All ages Other please specify: _____

STATE OF LOUISIANA
Blue Cross and Blue Shield of Louisiana is an independent member of our Blue Cross Blue Shield Association.

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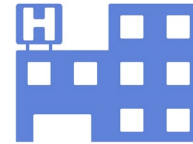
If information is missing from submitted recredentialing application, the provider is then contacted by a recredentialing specialist with a deadline to return the needed information. If not received timely, then provider may be terminated from the network. Accreditation standards prohibit us from listing providers as in-network past their recredentialing due date.

SUPPORTING DOCUMENTATION NEEDED FOR RECREDENTIALING PROCESS



Professional

- Completed credentialing form
- Completed Attachment A - Location Hours
- Copy of state license
- Copy of DEA registration and CDS license (*as applicable*)
- Copy of Malpractice Liability Certificate (*copy of policy declarations page*)
- A copy of the Collaborative Physician Agreement/Supervising Physician Agreement for NPs and PAs



Facility

- Completed credentialing form
- Completed attachment(s), as applicable
- Copy of state license
- Copy of W-9
- Copy of Malpractice Liability Certificate (copy of policy declarations page)
- Occupational License Tax or Operational License (as applicable)

How Members Find You

ONLINE PROVIDER DIRECTORIES

Louisiana Blue offers many networks. All providers do not participate in all networks. In order to maximize benefits for your patients, you need to know which networks you participate in. This information can be found online at www.lablue.com >Find a Doctor or Drug >Provider Directory and Cost Estimates.

The screenshot shows the Louisiana Blue website interface. At the top, there is a navigation bar with links for Employer, Producer, Provider, State Employee/Retiree, Federal Employee, Medicare, and Español. A search icon and 'Login or Sign Up' are also present. Below the navigation bar is the Louisiana Blue logo and a secondary navigation bar with links for Shop, Find a Doctor or Drug, Save, Wellness, Learn, and My Account. The main content area is titled 'Find a Doctor or Drug' and features a blue button with the same text. Below this, there are several sections: 'Provider Directory and Cost Estimates' (circled in blue), 'Other Directories' (listing BlueDental Provider Directory, Blue Vision Directory, Blue Cross Blue Shield Global Core, and Federal Employee Program (FEP)), 'Hospital Based Physicians' (with ER/OR Information), 'Get Care from Anywhere!' (with Medical/Behavioral Visits Available), 'Rx Drug Resources' (with Find and Manage Medicine and Pharmacy Directory), and 'Blue Distinction Centers'.

ONLINE PROVIDER DIRECTORIES

- You can search for a provider by name or specialty.
- To refine your search, select a **Network** and/or enter your location in the **city, state or ZIP** field. You can skip this by logging in to your account, so that your network and location are automatically selected.

The screenshot shows the Louisiana Online Provider Directory website. At the top left is the Louisiana state logo with the word "Louisiana". At the top right, there is a language selector set to "English" and a "Log In" button. The main header area is dark blue and contains the text "Good Morning!" and "Browse or search to find the care you need." Below this, there are two dropdown menus: "Network" set to "All Networks" and "City, state or zip" set to "Sunshine, LA - 70780". A large white search bar with a magnifying glass icon is positioned below the dropdowns. Underneath the search bar, there are "Common Searches" with links for "Primary Care", "Urgent Care", "Behavioral Health", and "DME & Medical Supplies". At the bottom, there is a "Browse by Category" section with three cards: "Medical Procedures" (with a document icon), "Medical Specialties" (with a stethoscope icon), and "Urgent Care Center" (with a truck icon and a brief description: "Walk-in clinic that treats illness or injury requiring immediate care, but not serious...").

ONLINE PROVIDER DIRECTORIES

- To find a provider in a particular network, select a network from the **Network** dropdown menu.
- The networks are listed in alphabetical order, or you can search "All Networks."
- If you log in to your account, you can skip this step because your network and location will be automatically selected.

The screenshot shows the Louisiana online provider directory interface. At the top left is the Louisiana logo. On the right, there is a language selector set to 'English' and a 'Log In' button. The main heading reads 'Good Morning! Browse or search to find the care you need.' Below this, there is a search bar with a dropdown menu for 'Network' currently set to 'All Networks'. The dropdown menu lists several network options: 'All Networks' (checked), 'Abbeville General', 'Affinity Health Network', 'Blue Connect EPO', 'Blue Connect HMO/POS', and 'Community Blue EPO'. To the right of the search bar, there is a location field set to 'Sunshine, LA - 70780'. Below the search bar, there are 'Common Searches' for 'Primary Care' and 'DME & Medical Supplies'. At the bottom, there is a 'Browse by Category' section with three categories: 'Medical Procedures', 'Medical Specialties', and 'Urgent Care Center'. The 'Urgent Care Center' category includes a description: 'Walk-in clinic that treats illness or injury requiring immediate care, but not serious...'.

ONLINE PROVIDER DIRECTORIES

- To search by medical specialty, type in a specialty or term in the search bar box, and then click the result for which you're searching in the dropdown menu.
- If you do not see the specialty you need in the dropdown menu, then click the blue magnifying glass button to the far right of the search bar to get more search results.

The screenshot displays the Louisiana provider directory website. At the top left is the Louisiana state logo and the word "Louisiana". On the top right, there is a language selector set to "English" and a "Log In" button. The main header area is dark blue with the text "Good Morning!" and "Browse or search to find the care you need." Below this, there are two dropdown menus: "Network" set to "Preferred Care PPO" and "City, state or zip" set to "Sunshine, LA — 70780". A search bar is open, showing the search term "family" and a magnifying glass icon. Below the search bar, there are three tabs: "All Results", "Names", and "Specialties" (which is selected). Under the "Specialties" tab, a list of search results is shown:

- Family Medicine**
Diagnose and treat a wide variety of typical diseases and conditions, usually in a primary care capacity.
- Marriage and Family Counselor**
Works with couples and families to solve problems with talk therapy.
- General Practice**
Diagnose and treat a wide variety of typical diseases and conditions, often in a primary care capacity.

At the bottom of the page, there is a "Find results" button and a "Less or injury but not serious..." link.

ONLINE PROVIDER DIRECTORIES

Each provider has a page with links:

- Provider Highlights
- Networks Accepted
- Specialties & Expertise
- Credentials
- Awards & Recognitions
- Ratings & Reviews
- Affiliated Facilities
- More About This Provider

The screenshot displays a provider profile for Joe Smith MD. At the top, there is a navigation bar with a back arrow, a profile picture, the name "Smith, Joe MD", gender "Male", and specialty "SPECIALTY: FAMILY PRACTICE". To the right, there are five stars, "(5.0) • 2 ratings", and buttons for "Print" and "Share".

Below the navigation bar is a sidebar with a red border containing the following links: "Provider Highlights", "Networks Accepted", "Specialties & Expertise", "Credentials", "Awards & Recognitions", "Ratings & Reviews", "Affiliated Facilities", and "More About This Provider".

The main content area is divided into two sections. The top section, "Provider Highlights", shows the provider's name "Smith, Joe MD" with a star icon and "(2)". It lists the provider's affiliation: "ABC Physician Group", address "1234 Main Street, Baton Rouge, LA 70809", and phone number "225-555-5555". It also indicates "Accepting New Patients" and lists awards: "2 Awards" and "1 Affiliation". A link "More about this provider's race, ethnicity, languages, etc." is provided. Network affiliations include "In 'Precision Blue HMO/POS' Network" (marked as a "QUALITY BLUE PROVIDER") and "Enhanced Tier 1".

The bottom section, "Networks Accepted", includes a "Log In" link for personalized results and a grid of insurance networks:

- (Enhanced Tier 1) Precision Blue HMO/POS
- (Tier 1) HMO Louisiana HMO/POS
- (Tier 1) OGB MagLocal Plus - PrefCare
- (Tier 1) OGB MagOpen Access - PrefCare
- (Tier 1) OGB Pelican HRA/HSA - PrefCare
- (Tier 1) OGB Preferred Care
- (Tier 1) Preferred Care PPO
- (Tier 1) Signature Blue HMO/POS
- (Tier 2) Abbeville General

ONLINE PROVIDER DIRECTORIES

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.lablue.com.

- Addresses (location information)*
- Phone numbers
- Accepting new patients
- Providers working at certain locations
- Information about telehealth services (telehealth/virtual-only providers are identified as such and address is not displayed)

For professional providers to be listed in our directories, they must be available to schedule patients' appointments a **minimum of 8 hours per week** at the location listed.

*Limit of 10 locations per provider per TIN.



It is the contractual responsibility of all participating providers to notify Louisiana Blue when they leave a group or location, as well as to keep all other information current. To report changes in your information, use the **Provider Update Request Form**. Our Provider Credentialing & Data Management Department will work with you to help ensure your information is current and accurate.

UPDATING YOUR INFORMATION

Our **Provider Update Request Form** accommodates all your change requests, which are handled directly by our Provider Data Management team.

It is important that we always have your most current information!

Louisiana Provider Update Request Form

Complete this form to report updated information on your practice to Blue Cross and Blue Shield of Louisiana. Based on your Type of Change needed, DocuSign® highlights the relevant fields to your request, and those fields appear in red throughout the form.

This request applies to: Individual Provider Provider Group/Clinic

CURRENT GENERAL INFORMATION		
Provider Last Name	First Name	Middle Initial
Tax ID Number	Provider National Provider Identifier (NPI)	
Group/Clinic Name	Group/Clinic National Provider Identifier (NPI)	
Are you a primary care provider (PCP)? <input type="checkbox"/> Yes <input type="checkbox"/> No	Specialty	Date of Requested Change

If you are an authorized representative completing this form on behalf of a provider, 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		
Check all applicable boxes below to indicate the information you wish to change. This allows you to complete the required sections of the forms, as appropriate.		
<input type="checkbox"/> Demographic Information	<input type="checkbox"/> Electronic Funds Transfer (EFT)	<input type="checkbox"/> Existing Providers Joining a New Provider Group (includes solo providers creating a new provider group)
<input type="checkbox"/> Termination Request	<input type="checkbox"/> Tax ID Number Change	<input type="checkbox"/> Add New Practice Location (Existing Tax ID)
<input type="checkbox"/> Remove Practice Location (Existing Tax ID)		

If you have any questions, please contact Provider Credentialing & Data Management at:
 Phone: 1-800-716-2299, option 2 Email: PCDMstatus@bcbsla.com

23007291 R06/23 Blue Cross and Blue Shield of Louisiana is an independent licensee of the Blue Cross Blue Shield Association. DocuSign® is an independent company that Blue Cross and Blue Shield of Louisiana uses to enable providers to sign and submit provider credentialing and data management forms electronically.

This form allows you to make any of the following changes. Simply check the appropriate box(es) to indicate the type of change needed. You may select more than one option.

TYPE OF CHANGE		
Check all applicable boxes below to indicate the information you wish to change. This allows you to complete the required sections of the forms, as appropriate.		
<input type="checkbox"/> Demographic Information	<input type="checkbox"/> Electronic Funds Transfer (EFT)	<input type="checkbox"/> Existing Providers Joining a New Provider Group (includes solo providers creating a new provider group)
<input type="checkbox"/> Termination Request	<input type="checkbox"/> Tax ID Number Change	<input type="checkbox"/> Add New Practice Location (Existing Tax ID)
<input type="checkbox"/> Remove Practice Location (Existing Tax ID)		

The form is available online at www.lablue.com/providers >Resources >Forms.

UPDATING YOUR INFORMATION

It is important that we always have your most current information!

- Indicate on the Provider Request Form the type of change you are requesting.
- You will **only** need to fill out the section of this form that needs updating. Completing the entire form is not required.

TYPE OF CHANGE		
Check all applicable boxes below to indicate the information you wish to change. This allows you to complete the required sections of the forms, as appropriate.		
<input type="checkbox"/> Demographic Information	<input type="checkbox"/> Electronic Funds Transfer (EFT) Termination or Change	<input type="checkbox"/> Existing Providers Joining a New Provider Group (<i>includes solo providers creating a new provider group</i>)
<input type="checkbox"/> Termination Request	<input type="checkbox"/> Tax ID Number Change	<input type="checkbox"/> Add New Practice Location (Existing Tax ID)
<input type="checkbox"/> Remove Practice Location (Existing Tax ID)		

UPDATING YOUR INFORMATION



Providers have one correspondence email listed.

It is important to keep this information up to date. This is the email address the recredentialing information is sent. This can be updated in the Demographic Information of the Provider Update Form.

TYPE OF CHANGE

Check all applicable boxes below to indicate the information you wish to change. This allows you to complete the required sections of the forms, as appropriate.

<input type="checkbox"/> Demographic Information	<input type="checkbox"/> Electronic Funds Transfer (EFT) Termination or Change	<input type="checkbox"/> Existing Providers Joining a New Provider Group (<i>includes solo providers creating a new provider group</i>)
<input type="checkbox"/> Termination Request	<input type="checkbox"/> Tax ID Number Change	<input type="checkbox"/> Add New Practice Location (Existing Tax ID)
<input type="checkbox"/> Remove Practice Location (Existing Tax ID)		

It is important
that we always
have your most
current
information!

UPDATING YOUR INFORMATION

Our **Provider Update Request Form** accommodates these change requests:

- ✓ **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.

UPDATING YOUR INFORMATION

It is important that we always have your most current information!

Some change selections on the **Provider Update Request Form** include a checklist of required supporting documentation needed to complete your request.

- Complete the checklist:
- 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.							
SECOND PHYSICAL ADDRESS (if necessary)							
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.							
CHECKLIST							
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.							

Page 2 of 2

UPDATING YOUR INFORMATION


When requesting a **Tax ID Number Change**, it may be required that the provider undergo the credentialing process again.

TYPE OF CHANGE		
Check all applicable boxes below to indicate the information you wish to change. This allows you to complete the required sections of the forms, as appropriate.		
<input type="checkbox"/> Demographic Information	<input type="checkbox"/> Electronic Funds Transfer (EFT) Termination or Change	<input type="checkbox"/> Existing Providers Joining a New Provider Group <i>(includes solo providers creating a new provider group)</i>
<input type="checkbox"/> Termination Request	<input checked="" type="checkbox"/> Tax ID Number Change	<input type="checkbox"/> Add New Practice Location (Existing Tax ID)
<input type="checkbox"/> Remove Practice Location (Existing Tax ID)		

- Most **professional providers** are already credentialed and simply changing Tax ID number does not require credentialing.
- **Facilities** changing Tax ID number must be credentialed under the new number.
- Credentialing is not required for **delegated providers** changing to or joining a non-delegated group when they are already credentialed through delegated group for the same specialty.
- New contracting is required when changing to a Tax ID number that is not already set up in our system.

ATTESTING TO YOUR DIRECTORY INFORMATION

Provider Attestation Form

 Louisiana

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

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

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

Page 1 of 3

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Our PCDM Department sends either a **prefilled Provider Attestation Form** via DocuSign® (or a spreadsheet to larger groups) every 90 days to providers listed in our online provider directories. These providers are **required to review** their information.



If the information is correct, then electronically give attestation, sign and return the form.



If any of the information is incorrect, please complete the Provider Update Request Form (a link is included in the attestation form). This allows us to update the information we publish in our directories.



Failure to complete this attestation of information will result in provider being removed from our online provider directories.

Supporting Our Providers

THE PCDM DEPARTMENT

Provider Network Setup, Credentialing, Contracting & Demographic Changes

Sam Measels

director, Provider Credentialing and Information

sam.measels@lablue.com

Kaci Guidry

manager, Provider Data Management & PCDM Status

kaci.guidry@lablue.com

Kristin Ross

manager, Provider Contract Administration

kristin.ross@lablue.com

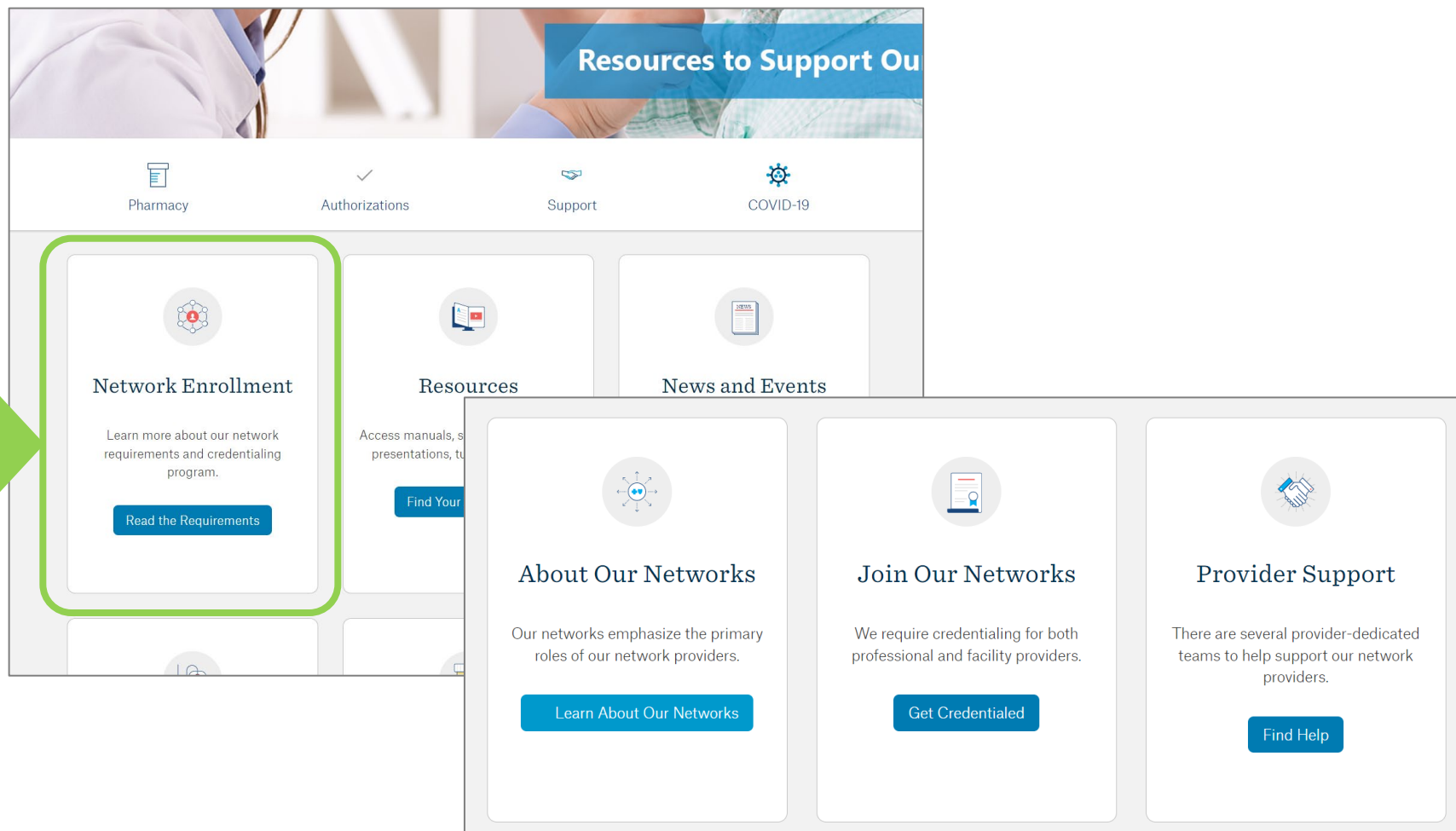
Brooke Schueneman

manager, Provider Data Integrity

brooke.schueneman@lablue.com

To check the status on your credentialing application or provider data update, please email PCDMstatus@lablue.com or call 1-800-716-2299, option 2.

THE PROVIDER PAGE www.lablue.com/providers

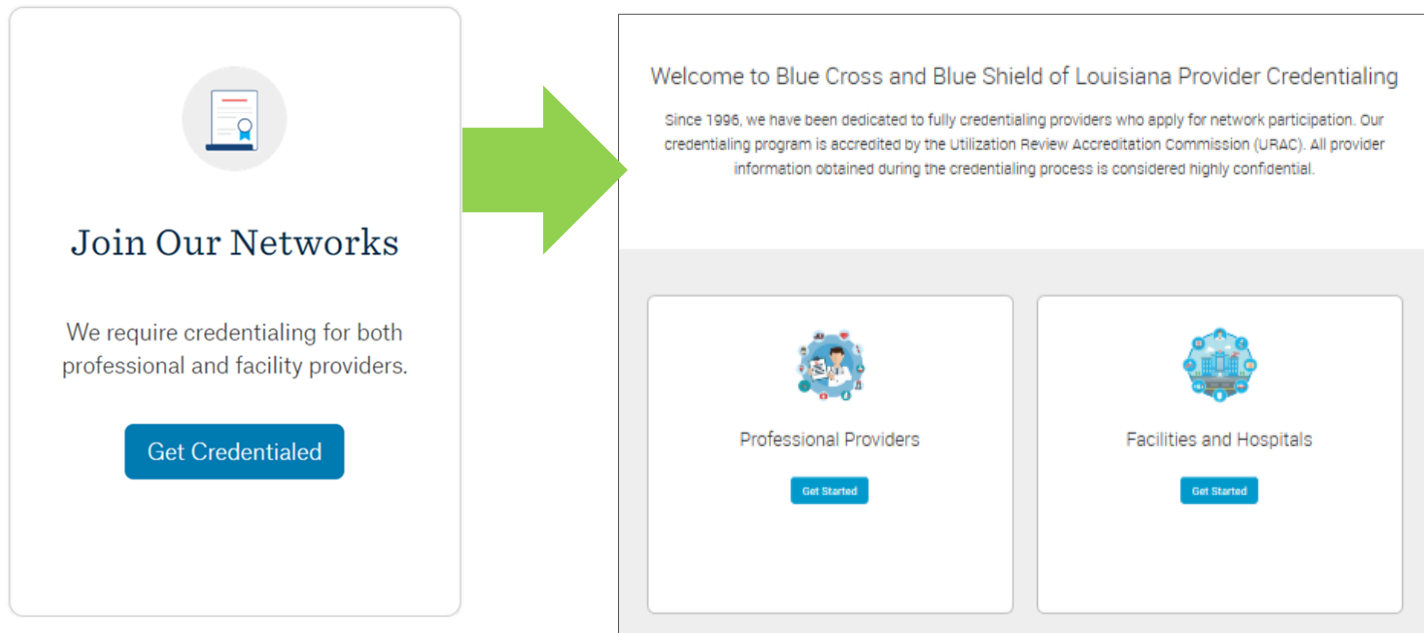


Choose **Network Enrollment** to view more information about our networks.

THE NETWORK ENROLLMENT PAGE

You **MUST** complete and submit documentation to start the process for credentialing **OR** to obtain a provider record.

Applications are available online at www.lablue.com/providers.



Choose **Network Enrollment**, then **Join Our Networks** page, then select **Professional Providers** or **Facilities and Hospitals** to find credentialing packets.

CREDENTIALING FAQs

The screenshot shows a navigation bar with five tabs: Overview, Credentialing Process, Join Our Networks, Update Your Information, and Frequently Asked Questions. The 'Frequently Asked Questions' tab is selected and highlighted in blue. Below the navigation bar, the page title is 'Frequently Asked Questions'. A sub-section titled 'Credentialing Application and Process' is expanded, indicated by a blue 'X' icon. The page contains seven FAQ items, each with a bold question and a paragraph of text. The questions cover topics such as the duration of the process, notification of application receipt, available forms, submission requirements, specialty-specific criteria, reimbursement requirements, and how to check for reimbursement approval.

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.lablue.com/providers >Network Enrollment >Join Our Networks
>Professional Providers/Facilities and Hospitals >Frequently Asked Questions

QUESTION TIME!

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



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

More Good Information

Easily Complete 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®

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 Louisiana Blue.

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.

View our *DocuSign® Guide* online at www.lablue.com/providers
>Network Enrollment >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 receipt. 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 SCBSLA.

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 Wesley
GENCO - SCBSLA

Please read the Electronic Record and Signature Disclosure document.
 I agree to use electronic records and signatures.

CONTINUE FINISH LATER OTHER ACTIONS +

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DocuSign® is an independent company that Blue Cross and Blue Shield of Louisiana uses to enable providers to sign and submit provider credentialing and data management forms electronically.

Easily Complete Forms with DocuSign®

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	Provider National Provider Identifier (NPI) - Please enter 10 numbers only with no special characters.	Middle Initial
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Tax ID Number	Group/Clinic Name	Group/Clinic National Provider Identifier (NPI)	
<input type="text"/>	<input type="text"/>	<input type="text"/>	
Are you a primary care provider (PCP)? <input type="radio"/> Yes <input type="radio"/> No	Effective Date of Service		
	<input type="text"/>		

Authorized representative completing this form on behalf of a

REPRESENTATIVE

Contact Phone Number	Contact Email Address
<input type="text"/>	<input type="text"/>

Submission Information (form completed by)

Signature of Authorized Representative	Date
<input type="text"/>	February 18, 2021

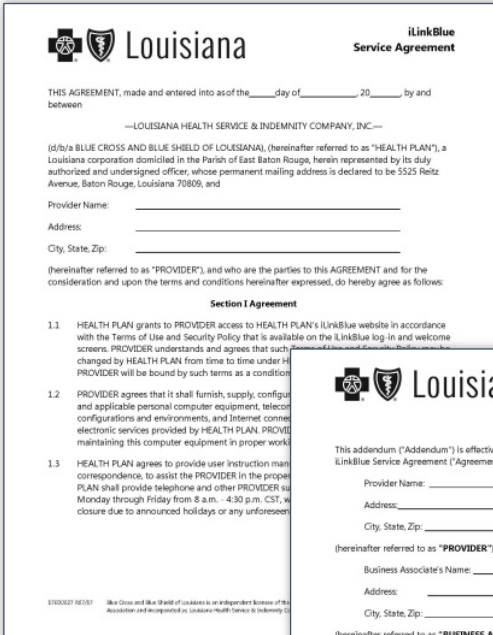
Navigation and Annotations:

- Navigation tool guides you through fields.** (Points to the START button)
- Instructions correspond to requirement of the active field.** (Points to the NPI field)
- Red outline indicates a required field.** (Points to the NPI field)
- Tooltips provide information about field requirements.** (Points to the NPI tooltip)
- FINISH, FINISH LATER, OTHER ACTIONS** (Points to the top navigation bar)

iLinkBlue Application

Included in the iLinkBlue packet:

- The **iLinkBlue Service Agreement** is a legal agreement between the provider and Louisiana Blue required for accessing iLinkBlue.
- 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 **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:

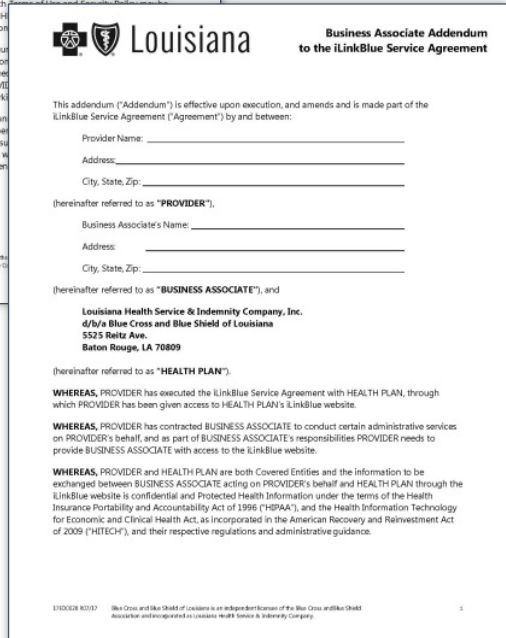
Section I Agreement

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 changed by HEALTH PLAN from time to time under HEALTH PLAN will be bound by such terms as a condition

1.2 PROVIDER agrees that it shall furnish, supply, configure and applicable personal computer equipment, telecommunication configurations and environments, and Internet connected electronic services provided by HEALTH PLAN, PROVIDER maintaining this computer equipment in proper work

1.3 HEALTH PLAN agrees to provide user instruction manual correspondence, to assist the PROVIDER in the proper PLAN shall provide telephone and other PROVIDER support Monday through Friday from 8 a.m. - 4:30 p.m. CST, with closure due to announced holidays or any unforeseen

11/03/2017 00:07 Blue Cross and Blue Shield of Louisiana is an independent licensee of the Association and incorporated as Louisiana Health Service & Indemnity Company



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.

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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 (SSS) 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--


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- EFT is a free provider service where Louisiana Blue 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 Louisiana Blue 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.

To change or update your Louisiana Blue payments via EFT, complete the **Provider Update Request Form**.

Administrative Representative Registration and Acknowledgement

- 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 Louisiana Blue 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 Louisiana Blue, you do not have to submit the Administrative Representative Registration Form.

LOUISIANA BLUE  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		
Provider Group/Clinic or Facility Name		
Address		
Phone Number		Provider Group/Clinic or Facility NPI
Individual Provider Name (if applicable)		Individual Provider NPI (if applicable)
Tax Identification Number		Is the Behavioral Health Authorizations Application needed?

ADMINISTRATIVE REPRESENTATIVE INFORMATION		
Administrative Representative Name		Title
Contact Phone Number	Email Address (this will be used for your unique username)	
Additional Phone Number	Additional Email Address	

MANAGER/OWNER INFORMATION		
Manager/Owner Name (other than the administrative representative)	Title	Date of Birth
Contact Phone Number	Email Address	

Return Form To:
 Email: 247team@lablue.com
 Fax: 1-800-515-1128
 Attn: Provider Identity Management

19WNC219 1/1/24 Louisiana Blue and Blue Shield of Louisiana is an

LOUISIANA BLUE  Administrative Representative Acknowledgment Form

I understand that I have been designated by my employer/organization (the Organization) as the Administrative Representative for the Organization for the purpose of obtaining and granting access to other Organization employees to Blue Cross and Blue Shield of Louisiana's secure online services (the Secure Services). As such, I am responsible for obtaining access to the Secure Services to appropriate users within my Organization and adhering to Louisiana Blue's guidelines regarding such access and delegation.

I agree that Secure Services access will be granted by me and the Organization only to those employees within the Organization who legitimately must have access to the Secure Services in order to fulfill their job responsibilities and only to the extent necessary to fulfill those job responsibilities, as is further described by Louisiana Blue's guidelines. I am also responsible for terminating Organization employee access to the Secure Services at such time as the employee changes roles or terminates employment with my organization, as applicable. I agree to implement procedures that will ensure that such terminations will be addressed promptly and in accordance with Louisiana Blue's guidelines.

As the Administrative Representative, I understand and agree that the Secure Services are assets of Louisiana Blue. Any misuse, personal use or use of the Secure Services for any business other than which I am authorized to perform on behalf of the Organization, or other than as set forth in Louisiana Blue guidelines, is strictly prohibited. I acknowledge that violation of this paragraph may result in criminal prosecution of the violator under federal and state laws, including, but not limited to, HIPAA. I further acknowledge that I must at all times, respect the confidentiality of all member/patient information or data that I am working with or may have access to in the Secure Services or otherwise on Louisiana Blue's electronic computer systems. In addition, I agree that I am obligated to protect the assets and/or confidential information on the Secure Services and on Louisiana Blue's electronic computer systems by maintaining complete secrecy over my username and password that I use to access the Secure Services. Under no conditions shall I reveal my username or password to anyone or allow anyone else access to or use of the Secure Services under my username.

I understand that if my role in the Organization changes or if my terms of employment ends with the Organization, it is my responsibility to ensure that my duties and access to the Secure Services immediately terminate as well. On behalf of the Organization, I acknowledge and agree that the Organization shall notify Louisiana Blue immediately of any breach of confidentiality, fraud, or suspected fraud or abuse of which it becomes aware relating to the Louisiana Blue Secure Services or any member/patient or other information contained in the Secure Services. In addition, I shall also immediately notify my Organization and Louisiana Blue of any such breach of confidentiality, fraud, or suspected fraud or abuse. I further understand that Louisiana Blue monitors the Secure Services and the access of users thereto. Louisiana Blue shall report to the Organization any suspected unauthorized access or abuse arising from the Organization's access to the Secure Services and, as a result, may also restrict my access to the Secure Services and take legal action as deemed necessary by Louisiana Blue in its sole discretion.

This Acknowledgment may be validly executed via facsimile transmission or through other electronic means showing the signature of the party and each such reproduced copy of this Acknowledgment shall constitute an original Acknowledgment for all purposes. Administrative Representative agrees that a facsimile or electronic scanned copy of this document with facsimile or scanned signatures may be treated as an original and will be admissible as evidence in a court of law.

Note: Customers with no sign-on activity for 180 days will automatically be locked. The administrative representative will need to contact the Provider Identity Management (PIM) Team at 247team@lablue.com or 1-800-716-2009, ext. 2 to reactivate the account. If the member does not use the account for 90 consecutive days, Louisiana Blue will terminate your user account; the Administrative Representative will need to contact the PIM Team for assistance. You will need to complete a new Administrative Representative Registration Packet. The packet is available on our website at www.lablue.com/online.

SIGNATURE PAGE FOLLOWS

19WNC219 1/1/24 Louisiana Blue and Blue Shield of Louisiana is an independent member of the Blue Cross Blue Shield Association.



The Administrative Representative Registration packet is also available online at www.lablue.com/providers >Electronic Services >Admin Reps.