

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.



Louisiana

CREDENTIALING, CONTRACTING, RE-CREDENTIALING & DATA MANAGEMENT

February 2024



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** Blue Cross has on your provider record.



THE BASICS

Credentialing Is Required for Network Participation



Blue Cross and Blue Shield of Louisiana 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.

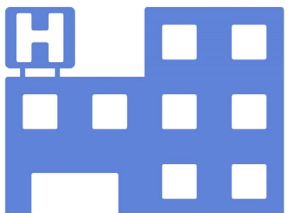
THE BASICS

We credential
professional



&

facility providers



Credentialing Is Required for Network Participation

- Since 1996, Blue Cross 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 Blue Cross 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 Blue Cross to provide covered services to our members.
- Payments are based on the provider's schedule of allowable charges.
- Provider may bill the member for any deductible, coinsurance, copayment and/or non-covered service. Provider agrees not to collect any amount over the allowable charge from the member.
- Payment goes directly to the participating provider.
- Participating providers see increased Blue Cross patient volume since members receive higher benefits when using network providers.
- Only participating providers are listed in our online provider directory featured on our corporate website (www.bcbsla.com).



What is a Non-participating Provider?

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



Applying for Credentialing

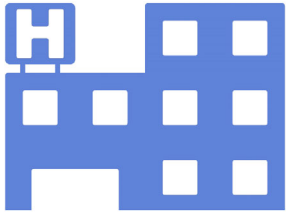


Professional Provider Network Availability

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 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.bcbsla.com/providers >Network Enrollment >Join Our Networks >Professional Providers >Credentialing Process.

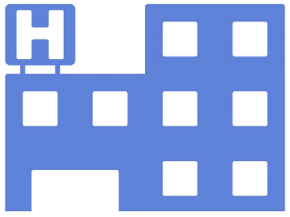


Facility Network Availability

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.bcbsla.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

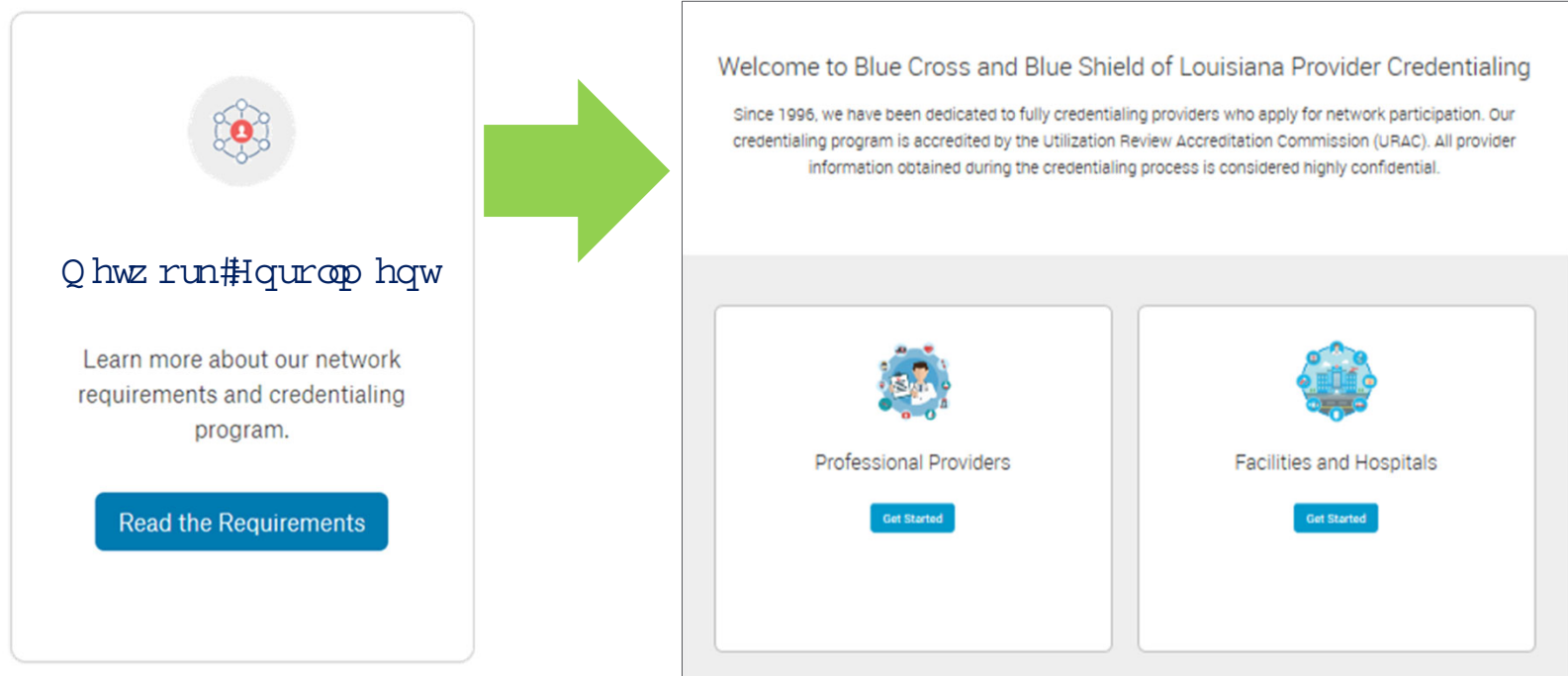
Our credentialing policy includes guidance for the provision of telehealth services to our members **WHEN:**

- **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.
- **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 Blue Cross 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.bcbsla.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. 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 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. Blue Cross uses the LSCA for both credentialing and recredentialing applications.

Professional Initial Credentialing Packet



The Professional (initial) credentialing packet includes a checklist of all required documents.

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




THE PAPERWORK for professional providers

Professional Initial Credentialing Packet

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

The **Checklist** must be completed.



Credentialing Checklist for Professional Providers

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

<input type="checkbox"/> I wish to PARTICIPATE in Blue Cross' network(s)	<input type="checkbox"/> I wish to obtain a Blue Cross record only as a NON-PARTICIPATING provider
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New Contract
Our Provider Contract Department will contact you regarding a new network agreement.

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

Joining an Existing Group
Upon approval, we will add you to existing network agreements applicable to your organization. Reimbursement during credentialing will apply from the date of your application.

- Complete the Louisiana Standardized Credentialing Application (if not currently credentialled)
 - Attachment A - Location Hours
- Enclose a copy of state license
- Enclose a copy of DEA/CDS Licenses (where applicable)
- Enclose a copy of Malpractice Liability Certificate (copy of policy declarations page)
- Enclose a copy of the Collaborating Physician Agreement/Supervising Physician Agreement (NP/PA). Collaborating physician must participate in the same network as the applicant.

- Complete the Louisiana Standardized Credentialing Application
- Complete the iLinkBlue Service Agreement
- Complete the Business Associate Addendum to the iLinkBlue Service Agreement
- Complete the Electronic Funds Transfer (EFT) Enrollment Form
- Complete the Administrative Representative Registration Form
- Complete the Administrative Representative Acknowledgment Form
- Enclose an EIN Letter
- Enclose a W-9 Form
- Enclose a copy of state license

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- 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.



THE PAPERWORK for professional providers

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

LOUISIANA STANDARDIZED CREDENTIALING APPLICATION

DIRECTIONS
Please type or print in black ink when completing this form. If you need more space or have more than four locations, attach additional sheets and reference the question being answered. Please see page 10 for a list of required documents.
** All sections must be completed in their entirety. "See C.V.", not acceptable**

GENERAL INFORMATION

Last Name: Suffix, First, Middle, Gender: Male, Female
 Degree: MD DO DPM DC DDS DMD Other
 Any other name under which you have been known? (AKA) Last, ECFMG Number, LPFN Number
 Home Street Address, City, State, Zip Code
 Home Phone Number, Pager Number/Answering Service, Home Email Address (optional)
 Social Security Number, Date of Birth, Birth Place (city, state), Race/Ethnicity (voluntary)
 NPI - Individual, Medicaid Provider Number, Medicare Provider Number

PRIMARY PRACTICE LOCATION

Institution/Group/Clinic Name (if Applicable), Office Manager
 Tax Identification Number, Effective Date of Provider at this Practice Location, NPI - Group
 Name to which Employer Identification Number (EIN) is registered with the IRS (**IMPORTANT: must match IRS information exactly**)
 Physical Address, City, State, Zip Code
 Office Email, Office Website
 Main Phone Number, Appointment Phone Number, Fax Number
 Billing Address (Where you want payments sent), Contact Person, Phone Number, City, State, Zip Code, Billing Email, Fax Number
 Correspondence Address (Where you want communications sent), Contact Person, Phone Number, City, State, Zip Code, Correspondence Email, Fax Number
 Medical Records Address (Where you want medical record requests sent), Contact Person, Phone Number, City, State, Zip Code, Medical Records Email, Fax Number
 Type of Practice: Solo Multi-specialty Group Single Specialty Group Hospital-based
 Hospital-employed Healthplan/Payor-owned
 If Hospital-employed or Healthplan/Payor-owned, please indicate owner name:
 Office Hours: Mon, Tues, Wed, Thur, Fri, Sat, Sun
 Do you practice at this location: Full-time Part-time Other (Specify) _____
 Languages spoken at this location (other than English): _____
 Provider Other
 Last Revised 03/2012 Page 1 of 10

The **LSCA Attachment A** is to report the hours per day the professional provider is available for patient appointments at each practice location.

- Location information reported must correlate to the locations reported on the LSCA, as applicable.
- This form is also used to report telehealth services.

Louisiana Credentialing Application Attachment A

Blue Cross and Blue Shield of Louisiana limits the published locations of professional providers in our online provider directories based on the ability to schedule patient appointments at each location. This form is required as an attachment to the professional credentialing application. Location information reported below must correlate to the locations reported on the credentialing application, as applicable. Please report the number of hours per day the professional provider is available for patient appointments at each practice location.

GENERAL INFORMATION

Individual Provider Last Name, First Name, Middle Initial
 Individual Provider NPI, Group/Clinic Tax ID Number

LOCATION INFORMATION
(Skip this section if completing the LSCA. Please complete this section if using the CAQH credentialing verification process.)

Billing Address (where you want payments sent)
 City, State, Zip Code, Billing Email, Telephone Number

Correspondence Address (where you want communications sent)
 City, State, Zip Code, Correspondence Email, Telephone Number

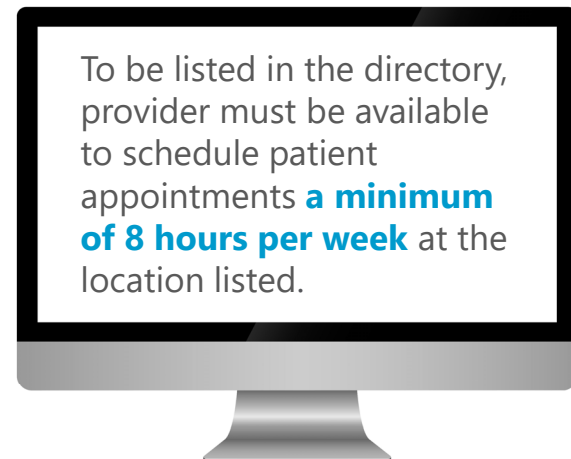
Medical Records Address (where you want medical record requests sent)
 City, State, Zip Code, Medical Records Email, Telephone Number

FOR THE PRIMARY PRACTICE LOCATION REPORTED ON THE CREDENTIALING APPLICATION

Group NPI
 Do you, the provider, offer telehealth services? Yes No By indicating "Yes," Blue Cross will identify the provider in our provider directories as offering telehealth services at this location.
 Practice Hours (available appointment hours):
 Mon, Tues, Wed, Thurs, Fri, Sat, Sun

For this practice location (please select at least one option):
 I am available to see patients at least 8 hours per week on a regular basis.
 I see patients here at least one day per month, but less than one day per week on a regular basis.
 I cover or fill in for colleagues within the same medical group on an as-needed basis only.
 I read tests or provide other services but do not see patients at this location.
 I do not practice here, but this location is within the medical group with which I am employed.

*This form is for professional providers only.
This form should be submitted with the Credentialing Application.*





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.—

ISSUE 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 I 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 screens. PROVIDER understands and agrees that such Terms of Use and Security Policy may be changed by HEALTH PLAN from time to time under HEALTH PLAN's sole discretion, and that PROVIDER will be bound by such terms as a condition of its use of the iLinkBlue website.
- 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.
dba/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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Business Associate Addendum

Louisiana Electronic Funds Transfer (EFT) Enrollment Form

To receive your Blue Cross and Blue Shield of Louisiana payments via electronic funds transfer (EFT), please complete the following information. Be sure to complete a separate Electronic Funds Transfer Enrollment Form for each payment location. Please contact your financial institution to arrange for the delivery of the CORE required minimum CSD+ Data Elements necessary for automatic re-association of the electronic funds transfer (EFT) payment with the CSD+ Data Elements service. See Guide to Completing the EFT Enrollment Form for detailed instructions (attached 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. 20:2038 to make 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, and advise that the timely Provider Payment Request 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

Practice Name: _____

Provider Address: Street _____

City _____ State/Province _____ Zip/Credit/Postal Code _____

PROVIDER IDENTIFIERS INFORMATION

Provider Number (has relationship between POC and Enrollment Identification Number 029)

National Provider Identifier (NPI) _____ Other NPI's (optional) _____

PROVIDER CONTACT INFORMATION

Telephone Number _____ Fax Number _____

RETAIL PHARMACY INFORMATION

Pharmacy Name _____

NCPDP Provider ID Number _____

FINANCIAL INSTITUTION INFORMATION

Financial Institution Name _____

Financial Institution	Routing Number	Type of Account or Financial Institution	Provider's Account Number with Financial Institution
Account Number (LinkBlue Provider Number)			
<input type="checkbox"/> Provider Tax Identification Number (TIN)			
<input type="checkbox"/> National Provider Identifier (NPI)			

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Electronic Funds Transfer (EFT) Enrollment Form

Louisiana Administrative Representative Registration Form

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

GENERAL PROVIDER INFORMATION

Practice or Facility Name _____

Address _____

Phone Number _____ National Provider Identifier (NPI) _____

Tax ID _____

ADMINISTRATIVE REPRESENTATIVE INFORMATION

Administrative Representative Name _____ Title _____ Date of Birth _____

Contact Phone Number _____ Email Address _____

MANAGER/OWNER INFORMATION

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

Contact Phone Number _____ Email Address _____

Return Form To:
 Email: ProviderIdent@bcbsla.com Mail: BCBSLA - Provider Identity Management
 P.O. Box 98029
 Fax: 1-800-555-1128 Baton Rouge, LA 70898-9029
 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.bcbsla.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.



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 (225) 297-2750 Attention: PCDM
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18NW2512 R07/19
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THE PAPERWORK for facilities

Blue Cross 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			
Accessible by public transportation:	Bus <input type="checkbox"/> Yes <input type="checkbox"/> No	Courier Service <input type="checkbox"/> Yes <input type="checkbox"/> No	Other				
Offers services for the disabled:	Text 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			
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							
Other (please specify):							

23XX0677 R03/18 1 of 6
Blue Cross and Blue Shield of Louisiana is an independent licensee of the Blue Cross and Blue Shield Association and incorporated as Louisiana Health Service & Indemnity Company.

- 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.—

ISSUE 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 I 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 screens. PROVIDER understands and agrees that such Terms of Use and Security Policy may be changed by HEALTH PLAN from time to time under HEALTH PLAN's sole discretion, and that PROVIDER will be bound by such terms as a condition of its use of the iLinkBlue website.
- 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.

23X0278 0017 Blue Cross and Blue Shield of Louisiana is an independent business of the Blue Cross and Blue Shield Association and incorporated as Louisiana Health Service & Indemnity Company.

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.
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.

23X0278 0017 Blue Cross and Blue Shield of Louisiana is an independent business of the Blue Cross and Blue Shield Association and incorporated as Louisiana Health Service & Indemnity Company.

Business Associate Addendum

Louisiana Electronic Funds Transfer (EFT) Enrollment Form

To receive your Blue Cross and Blue Shield of Louisiana payments via electronic funds transfer (EFT), please complete the following information. Be sure to complete a separate Electronic Funds Transfer Enrollment Form for each payment location. Please contact your financial institution to arrange for the delivery of the CORE required minimum CCDA Data Elements necessary for automatic re-association of the electronic funds transfer (EFT) payment with the CORE (CORE) 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. 20:303 to make 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 Request 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

Practice Name: _____

Provider Address: Street _____

City _____ State/Province _____ Zip/Credit/Postal Code _____

PROVIDER IDENTIFIERS INFORMATION

Provider Number (has relationship between POC and Coverage Identification Number (CIN))

Member Provider Number (MPN) _____ Group (NPI) Identification _____

PROVIDER CONTACT INFORMATION

Telephone Number _____ Email Address _____ Fax Number _____

RETAIL PHARMACY INFORMATION

Pharmacy Name _____ NCPDP Provider ID Number _____

FINANCIAL INSTITUTION INFORMATION

Financial Institution _____

Financial Institution	Routing Number	Type of Account or Financial Institution	Provider's Account Number with Financial Institution
Account Number (Linkage Provider Number)			
<input type="checkbox"/> Provider Tax Identification Number (TIN)			
<input type="checkbox"/> National Provider Identifier (NPI)			

23X0278 0016 Blue Cross and Blue Shield of Louisiana is an independent business of the Blue Cross and Blue Shield Association and incorporated as Louisiana Health Service & Indemnity Company.

Electronic Funds Transfer (EFT) Enrollment Form

Louisiana Administrative Representative Registration Form

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

GENERAL PROVIDER INFORMATION

Practice or Facility Name _____

Address _____

Phone Number _____ National Provider Identifier (NPI) _____

Tax ID _____

ADMINISTRATIVE REPRESENTATIVE INFORMATION

Administrative Representative Name _____ Title _____ Date of Birth _____

Contact Phone Number _____ Email Address _____

MANAGER/OWNER INFORMATION

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

Contact Phone Number _____ Email Address _____

Return Form To:
 Email: ProviderIdent@bcbsla.com Mail: BCBSLA - Provider Identity Management
 P.O. Box 98029
 Baton Rouge, LA 70808-9029
 Fax: 1-800-555-1120
 Attn: Provider Identity Management

23X0278 0016 Blue Cross and Blue Shield of Louisiana is an independent business of the Blue Cross and Blue Shield Association and incorporated as Louisiana Health Service & Indemnity Company.

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.bcbsla.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@bcbsla.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.



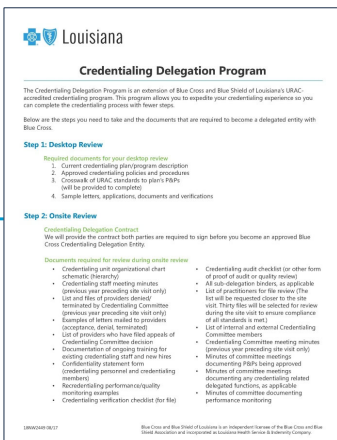
If you have questions about this process, you may email our Provider Relations Department at provider.relations@bcbsla.com.

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 Blue Cross to create their provider records.
- This program allows you to expedite your credentialing experience so you can complete the Blue Cross credentialing process with fewer steps.
- After a provider group is approved as a delegation entity, it will not be necessary to submit provider applications to be set up in the Blue Cross system.



If you have any questions about the Credentialing Delegation Program, please email credentialing.delegation@bcbsla.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 Blue Cross. This allows for in-network reimbursement on submitted claims during the credentialing process. Reimbursement during credentialing is backdated one month prior to the date of application receipt.

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@bcbsla.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 Blue Cross 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 Blue Cross 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 Blue Cross.

- 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.
- Blue Cross 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 BLUE CROSS

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

- Letter asking Blue Cross 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 Blue Cross and Blue Shield of Louisiana:

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 Blue Cross 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 Blue Cross.
- Includes multiple Blue Cross employees from Medical Management and Provider Credentialing & Data Management departments.





EFFECTIVE DATES

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

For participating providers, Blue Cross 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 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.

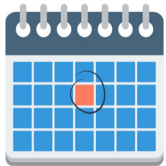
Signing the Contract

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@bcbsla.com.

THE NETWORK AGREEMENT the final paperwork



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

new agreement **IS REQUIRED** when:

- Newly credentialed solo practitioners
- Newly credentialed providers joining a group not currently participating with Blue Cross
- 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).
This is outlined on Slide 47.

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 joining a participating group, through Blue Cross' Delegated Credentialing Agreement program **and** that group has the applicable physician and/or allied agreement on file.

Staying in the Network

RECREDEENTIALING

The Credentialing Committee reviews all recredentialing applications.

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

Required applications:



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



facilities: Facility Credentialing Application and any applicable application attachments



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

RECREREDENTIALING



professional

Providers due for recredentialing are sent an email (provider 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.

OR

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.

The following forms for
recredentialing are accepted.

RECREREDENTIALING



facility

Facilities due for recredentialing are sent an email (provider 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

FACILITY CREDENTIALING 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 PETS

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

Charity - Acute Care Hospital Laboratory Renal Dialysis Center

Comprehensive Outpatient Lithotripter Facility Residential Treatment Center

 Rehabilitation Facility Long Term Acute Care Facility Retail Health Clinic

DME Outpatient Cardiac Catheterization Facility Rural Health Clinic*

Emergency Medicine Physicians Group Partial Hospitalization Program Skilled Nursing Facility (Free Standing)

Federally Qualified Health Center* Psychiatric Hospital (Free Standing) Sleep Disorder Clinic/Lab

Home Health Agency Psychiatric Hospital Specialty Pharmacy

Hospice Radiation Center State Owned Psychiatric Hospital

Hospital Urgent Care Clinic/Walk-In Clinic

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 TUE WED THU FRI SAT SUN

BILINGUAL

When should payments be sent?

Street Address: _____

City: _____ State: _____ ZIP Code: _____

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

When should communications be sent?

Street Address: _____

City: _____ State: _____ ZIP Code: _____

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

RECORDS

When should medical record requests be sent?

Street Address: _____

City: _____ State: _____ ZIP Code: _____

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

Does the office offer handicapped access for:
Building? Yes No Parking? Yes No Restroom? Yes No Other: _____

Accessible by public transportation:
Bus? Yes No Courier Service? Yes No Other: _____

Offers services for the disabled:
Text 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 populations you treat)
 0 to 6 7 - 11 12 - 18 19 - 65 Over 65 All ages Other (Please specify): _____

PAGE 1 OF 6

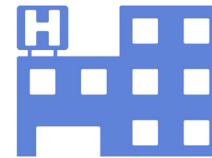
If information is missing from submitted recredentialing application, the provider is then contacted by a recredentialing specialist with a deadline to return the needed information. If not received timely, then provider may be terminated from the network.

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)

How Members Find You

ONLINE PROVIDER DIRECTORIES

www.bcbsla.com >Find a Doctor or Drug >Local Provider Directory

Positioned for Future Success:
Blue Cross and Blue Shield of Louisiana Enters Into Definitive Agreement to be Acquired by Elevance Health
Deal will result in \$3 billion foundation focused on improving Louisiana
[Read More](#)

Employer Producer Provider State Employee/Retiree Federal Employee Medicare Español

Shop Find a Doctor or Drug Save Wellne

Louisiana

THE RIGHT CARD.
The Right Care.

Your card opens the door to a large network of top doctors to care for you. You can rely on the strength of the Cross and the protection of the Shield.

[Shop Our Plans](#) [Account Login](#)

[Find Drugs](#) [Find a Doctor](#)

All Networks

- All Networks
- Preferred Care PPO
- HMO Louisiana HMO/POS
- Medical Dental Benefit
- Community Blue HMO/POS
- Blue Connect HMO/POS
- BlueHPN
- OchPlus
- Signature Blue HMO/POS
- Precision Blue HMO/POS
- OGB Preferred Care
- OGB MagLocal BR - CommBlue
- OGB MagLocal - BlueConn
- OGB MagLocal Plus - PrefCare
- OGB MagOpenAccess - PrefCare
- OGB Pelican HRA/HSA PrefCare
- Abbeville General
- TQHN
- Blue Connect EPO
- Affinity Health Network

Networks Available

- ★ = Enhanced Tier 1 \$
- = Tier 1 \$
- = Tier 2 \$\$
- = Tier 3 \$\$\$

1 HMO Louisiana HMO/POS
1 OGB MagLocal Plus - PrefCare
1 OGB MagOpenAccess - PrefCare
1 OGB Pelican HRA/HSA PrefCare
1 OGB Preferred Care
1 Preferred Care PPO

2 Abbeville General
2 Blue Connect HMO/POS
2 Community Blue HMO/POS
2 OchPlus
2 OGB MagLocal - BlueConn
2 OGB MagLocal BR - CommBlue
2 Precision Blue HMO/POS
2 Signature Blue HMO/POS
2 TQHN

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.bcbsla.com.

- Addresses (location information)
- Phone numbers
- Accepting new patients
- Providers working at certain locations
- Information about telehealth services

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.




It is the contractual responsibility of all participating providers keep their information current with Blue Cross. 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

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

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

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.

 **Provider Update Request**

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

CURRENT GENERAL INFORMATION

Provider Last Name	First Name	Middle Initial
Tax ID Number	Provider National Provider Identifier (NPI)	
Clinic Name	Clinic National Provider Identifier (NPI)	
Are you a primary care provider (PCP)? <input type="checkbox"/> Yes <input type="checkbox"/> No		

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

AUTHORIZED REPRESENTATIVE

Name	
Contact Phone Number	Contact Email Address

SUBMISSION INFORMATION (form completed by)

Signature of Authorized Representative	Date
--	------

PROVIDER ATTESTATION (where applicable)

Signature of Provider	Date
-----------------------	------

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

<input type="checkbox"/> Provider Information	<input type="checkbox"/> Electronic Funds Transfer (EFT) Termination or Change	<input type="checkbox"/> Existing Providers Joining a New Provider Group
<input type="checkbox"/> Terminate Network Participation	<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 3 Email: PCDMStatus@bcbsla.com

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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 (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.bcbsla.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

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

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

- ✓ **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):

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

SECOND PHYSICAL ADDRESS (if necessary)

Physical Address

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

Email Address

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

Accepting New Patients New Existing Only Other: _____

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

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):

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

CHECKLIST

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

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

Page 2 of 2

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 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 not 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

18NW3162 R05/22 Blue Cross and Blue Shield of Louisiana is an independent licensee of the Blue Cross Blue Shield Association.

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.

ATTESTATION OF TELEHEALTH SERVICES

Telehealth Attestation Form

- The Centers for Medicare & Medicaid Services (CMS) requires Blue Cross to verify if providers offer telehealth services.
- The Telehealth Status Attestation form will be sent by email to the Provider through DocuSign.
- Please do not decline the Telehealth Status Attestation form.
- If a “Yes” response is indicated for a location on the Telehealth Attestation form, BCBSLA will identify the provider in our provider directories as offering telehealth services at that location.

18NW3207 R08/22 **Page 1 of 2**
Blue Cross and Blue Shield of Louisiana is an independent licensee of the Blue Cross Blue Shield Association.

CMS defines telehealth as “professional consultations, office visits, and office psychiatry services through brief communication technology-based service/virtual check-in, remote evaluation of the pre-recorded patient information, and inter-professional internet consultation.”

Supporting Our Providers

THE PCDM DEPARTMENT

Provider Network Setup, Credentialing, Contracting & Demographic Changes

Sam Measels

director, Provider Credentialing and Information

sam.measels@bcbsla.com

Vielka Valdez

director, Provider Network Operations

vielka.valdez@bcbsla.com

Kaci Guidry

manager, Provider Data Management & PCDM Status

kaci.guidry@bcbsla.com

Kristin Ross

manager, Provider Contract Administration

kristin.ross@bcbsla.com

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

THE PROVIDER PAGE www.bcbsla.com/providers

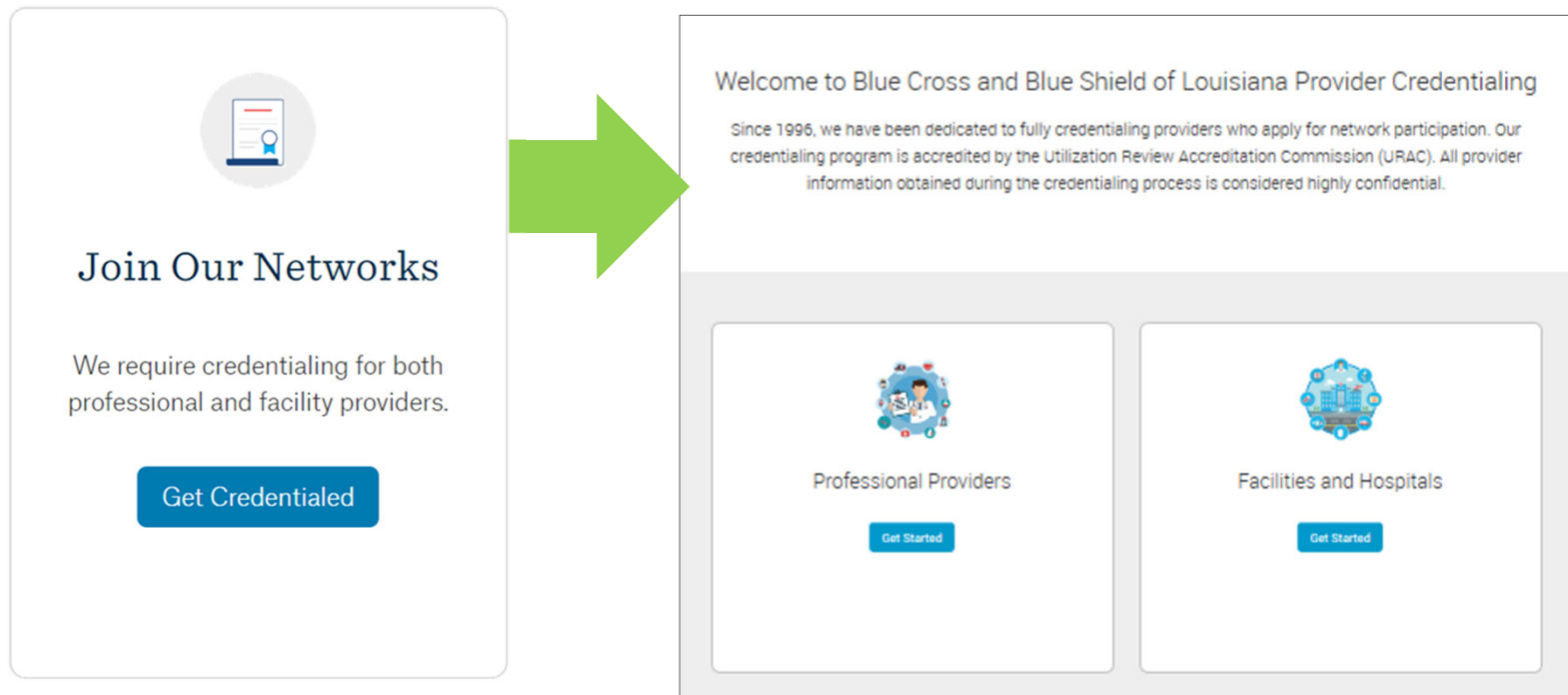
The screenshot displays the 'Resources to Support Our Providers' page. At the top, there is a navigation bar with icons for Pharmacy, Authorizations, Support, and COVID-19. Below this, a grid of content cards is shown. The 'Network Enrollment' card is highlighted with a green border and a green arrow pointing to it from the left. This card contains the text: 'Learn more about our network requirements and credentialing program.' and a 'Read the Requirements' button. A callout box on the right provides a detailed view of the 'Network Enrollment' card, showing its title, a brief description, and a 'Learn About Our Networks' button. Other visible cards include 'Resources' (with a 'Find Your' button), 'News and Events', 'About Our Networks' (with a 'Learn About Our Networks' button), 'Join Our Networks' (with a 'Get Credentialed' button), and 'Provider Support' (with a 'Find Help' button).

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.bcbsla.com/providers.



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

CREDENTIALING FAQs

Overview Credentiaing Process Join Our Networks Update Your Information **Frequently Asked Questions**

Frequently Asked Questions

✕ Credentiaing Application and Process


How long does it take to complete the credentiaing 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 credentiaing forms are available online?
BCBSLA offers both the [professional provider application](#) and the [facility credentiaing 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 credentiaing application?
If the provider is **NOT** credentiaed, please fully complete and submit the professional initial credentiaing packet. Facilities should submit the facility initial credentiaing packet.

How do I know what credentiaing 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 credentiaing?
Select provider types that meet specific criteria may be eligible for reimbursement during the credentiaing process.  [Click here](#) for full details.

How do I know if I have been approved for reimbursement during credentiaing?
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 credentiaing is effective. If you are not approved, your Record Assignment letter will notify you of the reason.

www.bcbsla.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@bcbsla.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 Blue Cross.

It allows you to electronically upload support documentation and even receive reminder alerts to complete submission and confirm receipt.

What is DocuSign?

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

View our *DocuSign® Guide* online at www.bcbsla.com/providers
>Network Enrollment >Join Our Networks >Professional
Providers/Facilities and Hospitals >Join Our Networks.

The screenshot shows a web page titled "DocuSign® Guide" for Louisiana. It provides instructions for providers on how to complete forms electronically. The page includes a "Step 1" section with a form titled "Provider/Recip Signer Information" and a "Step 2" section titled "Accept the Electronic Record and Signature Disclosure".

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

Provider/Recip Signer Information
Fill in the name and email for each signing role listed below. (Signers will receive an email alerting them to begin the document. Please enter your name and email to begin the signing process.)

Form Completed By

Your Name *
Last Name
First Name
Your Email *
Email Address

Provider
Please provide identification for any other signers needed for the document.
Name
Last Name
First Name
Email Address

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

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

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

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

Step 2: Accept the Electronic Record and Signature Disclosure

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

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

Please Review & Act on These Documents DocuSign

Clark Wolley
GENEO - BCBS LA

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

CONTINUE FINISH LATER OTHER ACTIONS

18N02798 01/20 Blue Cross and Blue Shield of Louisiana is an independent licensee of the Blue Cross and Blue Shield Association and incorporated as Louisiana Health Service & Indemnity Company.
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®

Enter text

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

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

START

Louisiana

Provider Update Request Form

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

This request applies to: Individual Provider Provider Group/Clinic

CURRENT GENERAL INFORMATION

Provider Last Name	First Name	Required - 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	<input type="text"/>	<input type="text"/>	<input type="text"/>
Group/Clinic	Group/Clinic Name	<input type="text"/>	<input type="text"/>
Are you a primary care provider (PCP)? <input type="radio"/> Yes <input type="radio"/> No	Effective Date of	<input type="text"/>	<input type="text"/>

Authorized representative completing this form on behalf of a

AUTHORIZED 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 tool guides you through fields.

Instructions correspond to requirement of the active field.

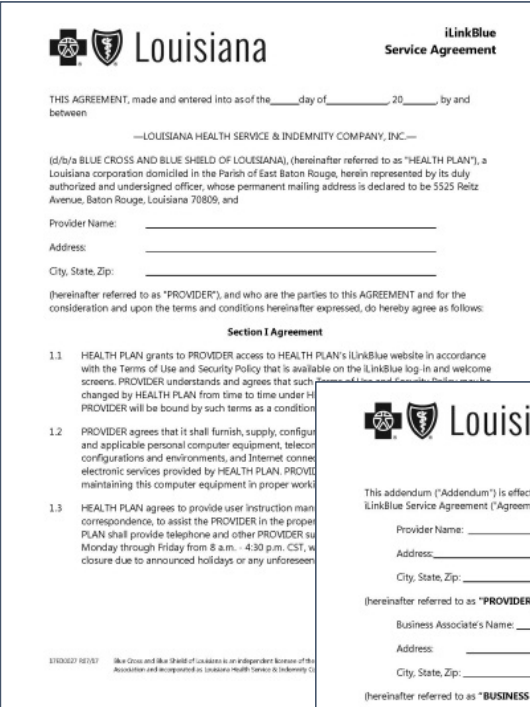
Tooltips provide information about field requirements.

Red outline indicates a required field.

iLinkBlue Application

Included in the iLinkBlue packet:

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

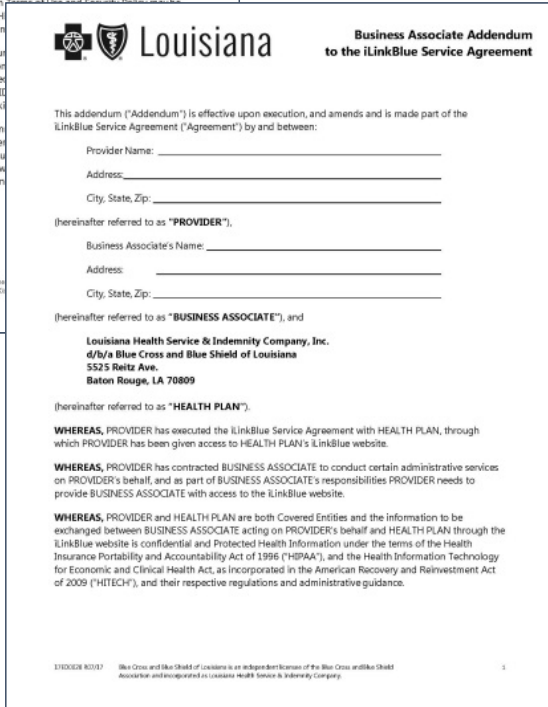
Provider Name: _____
Address: _____
City, State, Zip: _____

(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 information may be subject to change without notice and that PROVIDER will be bound by such terms as a condition of access.
- 1.2 PROVIDER agrees that it shall furnish, supply, configure and maintain its own computer equipment, telecommunication configurations and environments, and Internet connection and electronic services provided by HEALTH PLAN, PROVIDER shall maintain this computer equipment in proper working order.
- 1.3 HEALTH PLAN agrees to provide user instruction manual correspondence, to assist the PROVIDER in the proper use of the iLinkBlue website. PROVIDER 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 circumstances.

1/10/2007 R0107 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.

1/10/2007 R0107 Blue Cross and Blue Shield of Louisiana is an independent licensee of the Association and incorporated as Louisiana Health Service & Indemnity Company.

Electronic Funds Transfer (EFT) Enrollment Form

Louisiana Electronic Funds Transfer (EFT) Enrollment Form

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

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

PROVIDER INFORMATION
 Provider Name _____
 Provider Address: Street _____
 City _____ State/Province _____ Zip Code/Postal Code _____

PROVIDER IDENTIFIERS INFORMATION
 Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN) _____
 National Provider Identifier (NPI) _____ Group NPI (if applicable) _____

PROVIDER CONTACT INFORMATION
 Provider Contact Name _____ Title _____
 Telephone Number _____ Email Address _____ Fax Number _____

RETAIL PHARMACY INFORMATION
 Pharmacy Name _____
 NCPDP Provider ID Number _____

FINANCIAL INSTITUTION INFORMATION
 Financial Institution Name _____
 Financial Institution Routing Number _____ Type of Account at Financial Institution _____ Provider's Account Number with Financial Institution _____

Account Number Linkage to Provider Identifier
 Provider Tax Identification Number (TIN): _____
 National Provider Identifier (NPI): _____

~Over~

33XJ0276 R0216 Blue Cross and Blue Shield of Louisiana is an independent licensee of the Blue Cross and Blue Shield Association and incorporated as Louisiana Health Service & Indemnity Company.

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

To change or update your Blue Cross 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 Blue Cross online services:
 - iLinkBlue
 - BCBSLA authorizations
 - Behavioral health authorizations
 - Pre-service review for out-of-area members (BlueCard® members)
 - and more
- If you are part of a provider group or facility that already has registered an administrative representative with Blue Cross, you do not have to submit the Administrative Representative Registration Form.

Louisiana Administrative Representative Registration Form

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

GENERAL PROVIDER INFORMATION		
Provider Group or Facility Name		
Address		
Phone Number	Provider Group or Facility National Provider Identifier (NPI)	
Individual Provider Name (if applicable)	Individual Provider NPI (if applicable)	
Tax ID	Is the Behavioral Health Authorizations Application needed?	

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

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

Return Form To:
 Email: pimteam@bcbsla.com
 Fax: 1-800-515-1128
 Attn: Provider Identity Management

18M0236 R06/22 Blue Cross and Blue Shield of Louisiana is an insured member of the Louisiana Blue Cross and Blue Shield Association.

Louisiana 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 (BCBSLA) secure online services (the Secure Services). As such, I am responsible for delegating access to the Secure Services to appropriate users within my Organization and adhering to BCBSLA'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, all as further described by BCBSLA'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 BCBSLA's guidelines.

As the Administrative Representative, I understand and agree that the Secure Services are assets of BCBSLA. 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 BCBSLA's 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 BCBSLA's electronic computer systems. In addition, I agree that I am obligated to protect the assets and/or confidential information in the Secure Services and BCBSLA'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 term 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 BCBSLA immediately of any breach of confidentiality, fraud, or suspected fraud or abuse of which it becomes aware relating to the BCBSLA's Secure Services or any member/patient or other information contained in the Secure Services. In addition, I shall also immediately notify my Organization and BCBSLA of any such breach of confidentiality, fraud, or suspected fraud or abuse. I further understand that BCBSLA monitors the Secure Services and the access of users thereto. BCBSLA 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 record my access to the Secure Services and/or take legal action as deemed necessary by BCBSLA 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: Usernames 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 pimteam@bcbsla.com or 1-800-716-2299, option 5 to reactivate the account. iLinkBlue terminates your account if it remains inactive for one year. If iLinkBlue terminates 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.bcbsla.com/providers.

SIGNATURE PAGE FOLLOWS



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