Regence BlueCross BlueShield of Oregon is an Independent Licensee of the Blue Cross and Blue Shield Association

Regence BlueCross BlueShield of Oregon
Fax: 1 (888) 335-3002

Organizational Provider/Facility Credentialing/Recredentialing Application

GENERAL INFORMATION

Corporate Name (as assigned on CP 575 or 147C)	
Federal Tax Identification (TIN) Number	
NPI Number	Effective Date
Is the facility owned in whole or in part by a hospital system? ☐ Yes ☐ No	
Hospital System	

ORGANIZATIONAL PROVIDER TYPE

☐ Ambulatory Surgery Center
☐ Ambulance
☐ Residential Treatment Facility
  ☐ Substance Use Disorder: Indicate levels of care provided ______________________
  ☐ Mental Health: Indicate levels of care provided ______________________
☐ Behavioral Health Facility
  ☐ Mental Health - Intensive Outpatient Program
  ☐ Mental Health - Partial Hospitalization Program
  ☐ Substance Use Disorder - Intensive Outpatient Program
  ☐ Substance Use Disorder - Partial Hospitalization Program
☐ Substance Abuse, Alcohol, Drug Treatment Facility
☐ Applied Behavioral Analysis (ABA) Agency
☐ Birthing Center: ☐ Institution Affiliated ☐ Free Standing ☐ Home Based
☐ Durable Medical/Home Medical Equipment
☐ Home Health
☐ Home Infusion Therapy
☐ Hospice
☐ Hospital: ☐ Acute Care ☐ Critical Access
☐ Independent Diagnostic Testing Facility
☐ Kidney Dialysis Center
☐ Laboratory
☐ Orthotics/Prosthetics
☐ Radiology/Medical Imaging Centers (Free Standing or Mobile)
☐ Skilled Nursing Facility
☐ Sleep Disorder Center
☐ Mass Immunization Provider
☐ Other ______________________

Copy this page, prior to completing, for additional offices.

DEMOGRAPHIC/LOCATION INFORMATION

Please indicate the facility's main office, mailing, payment and contact information by completing the appropriate information and checking one or more address type.

ADDRESS #1 (choose both, if applicable): ☐ Primary Office ☐ Mailing

Facility/Organization Name (DBA)			
NPI Number		Effective Date	
Street Address			
City		State	ZIP Code
Phone Number	Fax Number		
Contact(s) at this address:			
Contact Name	E-mail Address		
Phone Number	Fax Number		

ADDRESS #2 (choose both, if applicable): ☐ Primary Office ☐ Mailing

Facility/Organization Name (DBA)			
NPI Number		Effective Date	
Street Address			
City		State	ZIP Code
Phone Number	Fax Number		
Contact(s) at this address:			
Contact Name	E-mail Address		
Phone Number	Fax Number		

ADDRESS #3 (choose both, if applicable): ☐ Primary Office ☐ Mailing

Facility/Organization Name (DBA)			
NPI Number		Effective Date	
Street Address			
City		State	ZIP Code
Phone Number	Fax Number		
Contact(s) at this address:			
Contact Name	E-mail Address		
Phone Number	Fax Number		

PAYMENT/BILLING INFORMATION

Reporting Name		
Corporate Name		
Tax ID Number		
Street Address		
City	State	ZIP Code
Billing Contact Name	Phone Number	
E-mail Address	Fax Number	

Please provide a copy of the W-9 IRS form

LICENSURE/CERTIFICATION/ACCREDITATION:

State License Number	Expiration Date
Is the facility a participating Medicare provider? ☐ Yes ☐ No	Medicare Number:
Is the facility a participating Medicaid provider? ☐ Yes ☐ No	Medicaid Number:
Accrediting Organization	
Effective Date	Expiration Date

Please provide a copy of all licenses and certificates and your most recent Centers of Medicare and Medicaid (CMS) survey with any site visit corrections showing that your facility is in compliance.

LIABILITY INSURANCE:

Insurance Carrier	Phone Number
Policy Number	Dates of Coverage
Dollar Amount per Occurrence	Dollar Amount Aggregate

Please provide a copy of your current professional and general liability insurance.

OWNERSHIP/MANAGEMENT INFORMATION:

President/CEO:

Name	
Title	Phone Number

Chief Financial Officer (CFO):

Name	
Title	Phone Number

Medical Director:

Name	
Title	Phone Number

OWNERSHIP/MANAGEMENT INFORMATION (continued):	
Other Managing Employees[1] or Persons with Ownership or Control Interest[2]:	
Name	
Title	Phone Number
Name	
Title	Phone Number
Name	
Title	Phone Number

ATTESTATION QUESTIONNAIRE:

If any of the following questions are answered "Yes", please provide details on a separate sheet.

1. ☐ Yes ☐ No Has the facility ever had or currently have pending, any legal actions excluding medical malpractice?
2. ☐ Yes ☐ No Has the facility ever been convicted of a crime, excluding misdemeanors?
3. ☐ Yes ☐ No Has any government agency ever investigated, suspended, revoked, or taken other action against your license to conduct business?
4. ☐ Yes ☐ No At any time, has any license or certification ever been revoked, denied, or suspended by others or voluntarily given up by the facility, or are any actions which may lead to such conclusions now under way?
5. ☐ Yes ☐ No At any time, has the facility been assessed a penalty, conviction or suspension or is the facility currently under investigation by the Medicaid or Medicare programs?
6. ☐ Yes ☐ No At any time, has any third party payors ever revoked, reduced, denied, or suspended your facility's participation due to inappropriate utilization management or any quality of care issues?
7. ☐ Yes ☐ No Has any managing employee or person with an ownership or control interest been excluded from participation in a government program (e.g., Medicare, Medicaid)?

[1] "Managing employee" means "a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of an institution, organization, or agency.

[2] "A Person with an ownership or control interest" means "a person or corporation that:

(a) Has an ownership interest totaling 5 percent or more in a disclosing entity;

(b) Has an indirect ownership interest equal to 5 percent or more in a disclosing entity;

(c) Has a combination of direct and indirect ownership interests equal to 5 percent or more in a disclosing entity;

(d) Owns an interest of 5 percent or more in any mortgage, deed of trust, note, or other obligation secured by a disclosing entity if that interest equals at least 5 percent of the value of the property or assets of a disclosing entity;

(e) Is an officer or director of a disclosing entity that is organized as a corporation; or

(f) Is a partner in a disclosing entity that is organized as a partnership."

STAFFING:

Does the facility validate the credentials for licensed practitioner employed or contracted at the facility? ☐ Yes ☐ No

If Yes, indicate how the facility conducts the credentialing process for each practitioner employed or contracted at the facility:

- ☐ Credentialing procedures are performed internally.
- ☐ Credentialing procedures are outsourced to ______________________________
- ☐ Other, specify ______________________________

If No, please explain: ______________________________

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EXCLUSION CERTIFICATION:

I hereby certify that the on-line exclusion lists for the Health and Human Services, Office of Inspector General (OIG) and General Services Administration (GSA) are checked for all new hires and monthly for existing employees to ensure that no excluded employees work on any jobs related to any Federal health care programs. I also hereby certify that I will remove any employee found on one of the above-referenced lists from any work related to a Federal health care program. The OIG exclusion list can be found at **http://exclusions.oig.hhs.gov/**. The GSA exclusion list can be found at **https://www.sam.gov/**.

Authorized Signature for Facility ▸	Date
Print Name	Title

RELEASE OF INFORMATION AND AUTHORIZATION:

I hereby certify that all responses and information provided pursuant to the above questions and requests are complete, accurate and current to the best of my knowledge and belief. I acknowledge that any misstatements in or omissions from this application constitute cause for denial or summary dismissal. Further, I give permission to verify the organizational providers credentials and by doing so hereby authorize release of the requested information concerning the organizational providers licensing, certification and accreditation. I warrant that I have the authority to sign this application on behalf of the entity for which I am signing in a representative capacity.

Authorized Signature for Facility ▸	Date
Print Name	Title