BlueCross BlueShield of Oklahoma

GROUP PROVIDER RECORD/CONTRACTING PACKET

The **Group Provider Record/Contracting Packet** should be completed by:

- A provider who has a practice with more than one professional provider
- A provider whose Federal Tax Identification Number has a corporate legal name
- A billing entity that is incorporated

The attached packet contains the forms required in order to be considered for network participation with Blue Cross and Blue Shield of Oklahoma (BCBSOK). Please fully complete all applicable information in its entirety. Completed packets can be emailed to Network Management *(preferred method)* or by fax or mail. The email address, fax number and mailing address are indicated below.

Please discard any older applications, as they are no longer valid.

Billing Information – The name that will appear on any reimbursement or Form 1099 will be that of the party to which payment is made. We will only make provider payments to the group or association that rendered the service(s) and supplied a TIN or EIN belonging to the named group or association.

Important – Please Note: ***Your assigned organization's BCBSOK internal Group Provider Record does NOT mean that your organization or your individual providers are participating providers or that a Group Contract will be offered.*** Until each of your affiliated providers are credentialed and contracted and have an effective date, all claims will be processed as out-of-network***.***

We look forward to assisting you in the future.

Complete the forms and return to:
EMAIL: OKNetworkManagement@bcbsok.com
Fax: 1-918-549-2141
Phone: 1-800-722-3730 (Say "NETWORK" or press 2)

MAIL: Blue Cross and Blue Shield of Oklahoma
Attn: Network Management Department
P.O. Box 3283
Tulsa, OK 74102-3283

Please complete all information within. This packet will be returned if incomplete.

Attach copies of:

- State Medical License
- W-9
- Behavioral Health Professional Areas of Expertise (if appropriate)
- Hospital Coverage Letter
- Federal DEA license and State Controlled Substance registration
- Medicare and/or Medicaid certification letters
- Malpractice Liability Insurance
- Call Coverage Form
- Supervising Physician Protocols and Duties Supplemental Questionnaire
- Prescribing Authority Supplemental Questionnaire
- Clinical Laboratory Improvement Amendments (CLIA) – if applicable
- Provider Disclosure of Ownership and Control Interest Form

A Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

602326.1214

BlueCross BlueShield of Oklahoma

GROUP INFORMATION

Applying for:	**Applying as:**	**BCBSOK Group Criteria:**
❑ Provider Record only ❑ Provider Record and Participation in the BCBSOK Network	❑ Primary Care Group ❑ Specialist Group ❑ Hospital Based Group *Anesthesia, Pathology, Radiology, Emergency Medicine ❑ Other Multi-specialty Group	Do you employ 100 or more providers? Yes ❑ or No ❑

Are you associated with:

❑ IPA (Independent Physician Association) Name:_____

❑ PHO (Physician Hospital Organization) Name:_____

❑ Designated Essential Community Provider – examples: RHC, FQHC, Tribal or Planned Parenthood

Name: _____

❑ Health System Name:_____ Employed? Yes ❑ or No ❑

Group/Company Name: _____

Type 2 Organizational NPI:_____ Tax Identification Number (TIN):_____

Taxonomy Codes:_____

Employer Identification Number (EIN):_____

Is this your personal taxpayer number? Yes ❑ No ❑

Does it belong to a Corporation, partnership, etc.? Yes ❑ No ❑

Supervising Physician(s) if applicable:_____

Physical Address

(Attach a separate sheet for any additional addresses **with phone numbers, office hours and services performed**)

Address: _____

City: _____ State: _____ Zip: _____ County: _____

Appointment Phone #: _____ Fax #: _____

Email address:_____

Contact name: _____ Phone # _____

Office Hours:

Mon _____ to_____ | Tue_____ to_____ | Wed _____ to_____ | Thu _____to_____ |

Fri _____ to_____ | Sat _____to_____ | Sun _____to_____ |

A Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

BlueCross BlueShield of Oklahoma

Billing/Payee Address (Mail Check To):

Address: _____

City: _____ State: _____ Zip: _____ County: _____

Phone #: _____ Fax #: _____

Email Address: _____

Contact Name: _____ Phone # _____

Place of Service Codes Billed: _____

Credentialing/Correspondence Address:

Address: _____

City: _____ State: _____ Zip: _____ County: _____

Phone #: _____ Fax #: _____

Email Address: _____

Contact Name: _____ Phone # _____

Practitioner Information

Please complete a ***Solo Practitioner Packet*** for each practitioner in the group

GROUP INFORMATION
1. Are you currently a Medicare provider in Oklahoma? Yes ❑ No ❑ Medicare PTAN:_____
2. Are you currently a Medicaid provider in Oklahoma? Yes ❑ No ❑ Medicaid Number: _____
3. Does this facility have wheelchair access? Yes ❑ No ❑
4. Does the physical location provide screening mammography services? Yes ❑ No ❑ Scheduling Phone Number:
5. Any limitations to practice (e.g., gyn only, only up to 18 years of age, females only, etc)
6. Any limitations to weekly practice hours (please list open days and hours of business):
7. Do you or your staff speak other languages? Yes ❑ No ❑ If yes, which languages:
8. Do you render laboratory services? Yes ❑ No ❑ If Yes, please provide your CLIA number and describe testing methodology performed. CLIA Number: _____ Testing Methodology: _____
9. Where do you render services for this location? (i.e. office, hospital, surgery center, etc):_____
10. Place of Service (POS) Codes Billed (i.e. office- POS 11, hospital- POS 21, surgery center- POS 24, etc): _____
11. Services Performed at this location: _____

Continued on next page

A Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

BlueCross BlueShield of Oklahoma

GROUP INFORMATION (continued)

12. Do you render Telemedicine Services? Yes ❑ No ❑
    Are you physically located in Oklahoma at the time services are rendered? Yes ❑ No ❑. If No, please explain:

_____

_____

_____

13. Have you ever been convicted of a felony or fraud?	Yes ❑ No ❑
14. Has your license to practice medicine in any jurisdiction ever been suspended or revoked?	Yes ❑ No ❑
15. Does your physical/mental health limit you in any way from performing your duties as a physician?	Yes ❑ No ❑
16. While practicing medicine, have you ever been impaired by alcohol or other chemical substances?	Yes ❑ No ❑
17. Have your privileges at any hospital ever been restricted, revoked, or not renewed?	Yes ❑ No ❑
18. Have you ever been listed on an OIG or other government sanction list?	Yes ❑ No ❑
19. Have you ever been Debarred by Medicare/Medicaid?	Yes ❑ No ❑
20. Have you ever been a BCBSOK Participating provider before?	Yes ❑ No ❑

If you answered *yes* to any of the above questions, please include a detailed letter of explanation.

Comments or additional information you would like to provide:

To the best of my knowledge, the information supplied on this document is accurate and complete.

Upon submission of this application, group provider hereby releases this information to Blue Cross and Blue Shield of Oklahoma for the purpose of establishing a BCBSOK Group Provider Record.

Please complete all information above. This form will be returned if incomplete.

_____ Name of Signatory

_____ Title of Signatory

_____ Authorized Signature

_____ Date Signed

INTERNAL USE ONLY
PAR / PPO / EPPN / CAR / P65 / WCO / HMO / BAV PPO / MA PPO / MA HMO
PROVIDER ID: _____CONTRACT ID:_____

SIGNATURE TYPE: HAND / ELEC. / ROSTER
PRACTICING AS: PCP / SPECIALIST / ALEX

A Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

BlueCross BlueShield of Oklahoma

Provider Disclosure of Ownership and Control Interest Form

Name of Entity/Individual	TIN	NPI

1. Has the disclosing provider, or any "person who has ownership or control interest" in the disclosing provider, or any person who is an "agent" or "managing employee" of the disclosing provider, been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the Title XX services program since the inception of those programs? (Definitions may be found at 42 CFR Sections 101, et seq.). If yes, give the name(s) of person(s) and description(s) of offense(s). Please use additional pages if necessary:

Name	TIN	Date of Birth	Description

2. Definition: A managing employee is 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 operations of an institution, organization, or agency." (42 CFR section 455.101) Managing employees are in a position to exert influence over the conduct of the provider's operations and includes officers, governing boards, or board of directors.

Name	TIN	Address	Date of Birth

3. Provide the name and address of each person with an ownership or control interest in the disclosing provider or in any subcontractor in which the disclosing provider has direct or indirect ownership of five percent or more. For corporations that have an ownership or control interest in the disclosing entity, please separately list its primary business address, every business location and Post Office Box address. Please use additional pages if necessary:

Name	TIN	Address	Date of Birth

4. Is any person named in question #3 related to another as spouse, parent, child, or sibling? If yes, give the name(s) of person(s) and relationship(s). Please use additional pages if necessary. *NOTE: Designate relationship to each person listed in question #3 by using A., B., C., etc.*

Name	Relationship

Certification:

I certify that the above disclosed information is true and correct to the best of my knowledge as of the date set forth below.

Signature _____ **Date** _____

Title _____ **Position** _____

Printed name _____