Blue Cross and Blue Shield of Nebraska Institutional/Facility Credentialing Application

Thank you for your inquiry to apply to participate in Blue Cross and blue Shield of Nebraska (BCBSNE) network. At this time, we are requesting the below application be completed in its entirety along with all necessary attachments. **Failure to complete in a timely manner will result in delayed processing.**

Please refer to our Institutional/Facility Standards Matrix on NebraskaBlue.com/Providers/Credentialing for additional details and requirements.

GENERAL INFORMATION

Name of Representative Completing the Application: ______________________

Email Address: ______________________

Phone Number: ______________________

PRACTICE/PHYSICAL LOCATION INFORMATION

Complete for each location servicing BCBSNE members (attach a separate sheet for additional locations)

Facility Name: ______________________

Address Line 1: ______________________

Address Line 2: ______________________

City: ____________ State: ____________ ZIP Code: ____________

Phone Number: ____________ Fax Number: ____________

Provider NPI Number: ____________ Tax ID Number: ____________

Taxonomy(s) Requested (This does not guarantee we'll be able to list, but does assist with credentialing):

____

Mailing Information (if different than physical address above):

Address Line 1: ______________________

Address Line 2: ______________________

City: ____________ State: ____________ ZIP Code: ____________

Phone Number: ____________ Fax Number: ____________

Billing Information (if different than physical address above):

Address Line 1: ______________________

Address Line 2: ______________________

City: ____________ State: ____________ ZIP Code: ____________

Phone Number: ____________ Fax Number: ____________

Credentialing Request (Check ONE. If multiple specialties, please submit an additional application).

- ☐ Ambulance
- ☐ Ambulatory Surgery Center (ASC)
- ☐ Birthing Centers
- ☐ Diabetic Education Program
- ☐ Durable/Home Medical Equipment Supplier (DME)
  - ☐ Provides Breast Pump Supplies
- ☐ Home Health Agency (HHA)
- ☐ Home Infusion Therapy
- ☐ Hospice
- ☐ Hospital
- ☐ Independent Clinical Laboratory
- ☐ Independent Diagnostic Testing Facility
- ☐ Inpatient Psych
- ☐ Intensive Outpatient Behavioral Center
- ☐ Medication Assisted Treatment Facility
- ☐ Pharmacy (with DME)
- ☐ Radiology Center
- ☐ Rehabilitation
- ☐ Renal Dialysis Center
- ☐ Residential Treatment Center
- ☐ Skilled Nursing Facility
- ☐ Swing Bed
- ☐ Urgent Care Center
  (also required to review Facility Standards for Urgent Care Standards)
- ☐ Other: ______________________

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1. Has the facility's/provider's license to practice in any jurisdiction ever been limited, restricted, revoked, suspended, voluntarily relinquished, terminated, subjected to disciplinary action or otherwise acted upon in an adverse manner?

   ☐ No

   ☐ Yes, please explain: ______________________

2. Has the facility/provider ever been sanctioned or penalized by any hospital, licensing board, government entity or managed care organization?

   ☐ No

   ☐ Yes, please explain: ______________________

3. Has the facility/provider ever been disciplined, excluded from, debarred, suspended, reprimanded, sanctioned, censured, disqualified or otherwise restricted regarding participation in Medicare or Medicaid programs or other federal or state government health care plans or programs?

   ☐ No

   ☐ Yes, please explain: ______________________

4. Is the facility/provider part of a Quality Improvement Program?

   ☐ No

   ☐ Yes, please explain: ______________________

5. Provide the names of all professionals who are rendering services at the facility. All providers at the facility will need to be credentialed with BCBSNE through our practitioner credentialing process. (Attach a listing on a separate sheet, if applicable)

6. Have any liability claim settlements, not involving litigation or arbitration, been paid by the facility/provider within the last 10 years?
   - ☐ No
   - ☐ Yes, please explain: ____________________

7. Have any liability judgments been entered against the facility/provider, including arbitration, or are there any suits pending within the last 10 years?
   - ☐ No
   - ☐ Yes, please explain: ____________________

8. Has the facility/provider ever been denied liability insurance, in whole or in part within the last 10 years?
   - ☐ No
   - ☐ Yes, please explain: ____________________

9. Has a policy ever been canceled, involuntarily restricted, denied renewal, or rated up because of the nature or volume of claims against the facility/provider within the last 10 years?
   - ☐ No
   - ☐ Yes, please explain: ____________________

10. Has there been any other material changes in the last three years?
   - ☐ No
   - ☐ Yes, please explain: ____________________

11. State licensure information, including current license(s) and history of licensure in all jurisdictions.

    ____

12. Is the facility/provider accredited?
   - ☐ No, please explain: ____________________
   - ☐ Yes, please list all accreditations (attached copy is required.): ____________________

   Refer to the Institution/Facility Standards Matrix at NebraskaBlue.com/Providers/Credentialing for requirements

13. Is the facility/provider Medicare certified? If yes, please provide certification number. If no, please explain.
   - ☐ Yes, certification number: ____________________
   - ☐ No, please explain: ____________________

   Attached copy of Medicare Certification/PTAN letter required.

14. Liability Insurance (must include General Liability Insurance) (attached copy is required):

    Policy Number: ____________________

    Policy Limits: ____________________

    Expiration Date: ____________________

15. Diabetic education program Certification (attached copy is required if applicable):

    ____

16. Total number of Medicare-certified beds (if applicable):

    ____

17. Name of Facility Administrator (if applicable):

    ____

18. Name of Medical Director (if applicable):

    ____

19. If an Air Ambulance provider, is the organization part of a hospital-owned or sponsored program, municipality sponsored program, hospital-independent partnership (hybrid) program, independent program, or tribally operated program in Alaska?"

    ____

I represent that I have personally completed this application or have reviewed the completed application. I acknowledge any material misstatements or omissions from the application may be grounds for rejection and refusal of BCBSNE to consider any future applications. I represent all the information submitted in this application is complete and correct to the best of my knowledge.

I agree to notify BCBSNE if there is any change in the status or condition that would alter responses to any information in this application.

Signature ______________________ Title ______________________

Date ______________________

Email Address: ______________________ Phone Number: ______________________

IMPORTANT REMINDERS

This form must be completed in its entirety.

Copies of licenses, accreditations, insurance, etc. must be current and attached.

Incomplete applications will delay processing and could result in being returned for completion or termination.

Refer to NebraskaBlue.com/Providers/Credentialing for questions.

RETURN THIS FORM AND ATTACHMENTS VIA:

EMAIL:
CredentialingRequests@NebraskaBlue.com
(This email is only to be used to submit applications and is not monitored for inquiries.)

FAX:
402-392-4148

MAIL:
Blue Cross and Blue Shield of Nebraska
Attn: Credentialing Department
1919 Aksarben Drive
PO Box 3248
Omaha, NE 68180

Standard Authorization, Attestation and Release

(Not for Use for Employment Purposes)

I understand and agree that, as part of the credentialing application process for participation, membership and/or clinical privileges (hereinafter, referred to as "Participation:) at or with each healthcare organization indicated on the "List of Authorized Organizations" that accompanies this Provider Application (hereinafter, each healthcare organization on the "List of Authorized Organizations" is individually referred to as the "Entity"), and any of the Entity's affiliated entities, I am required to provide sufficient and accurate information for a proper evaluation of my current licensure, relevant training and/or experience, clinical competence, health status, character, ethics, and any other criteria used by the Entity for determining initial and ongoing eligibility for Participation. Each Entity and its representatives, employees, and agent(s) acknowledge that the information obtained relating to the application process will be held confidential to the extent permitted by law.

I acknowledge that each Entity has its own criteria for acceptance, and I may be accepted or rejected by each independently. I further acknowledge and understand that my cooperation in obtaining information and my consent to the release of information do not guarantee that any Entity will grant me clinical privileges or contract with me as a provider of services. I understand that my application for Participation with the Entity is not an application for employment with the Entity and that acceptance of my application by the Entity will not result in my employment by the Entity.

Authorization of Investigation Concerning Application for Participation. I authorize the following individuals including, without limitation, the Entity, its representatives, employees, and/or designated agent(s); the Entity's affiliated entities and their representatives, employees, and/or designated agents; and the entity's designated professional credentials verification organization (collectively referred to as "Agents"), to investigate information, which includes both oral and written statements, records, and documents, concerning my application for Participation. I agree to allow the Entity and/or its Agent(s) to inspect and copy all records and documents relating to such an investigation.

Authorization of Third-Party Sources to Release Information Concerning Application for Participation. I authorize any third party, including, but not limited to, individuals, agencies, medical groups responsible for credentials verification, corporations, companies, employers, former employers, hospitals, health plans, health maintenance organizations, managed care organizations, law enforcement or licensing agencies, insurance companies, educational and other institutions, military services, medical credentialing and accreditation agencies, professional medical societies, the Federation of State Medical Boards, the National Practitioner Data Bank, and the Health Care Integrity and Protection Data Bank, to release to the Entity and/or its Agent(s), information including otherwise privileged or confidential information, concerning my professional qualifications, credentials, clinical competence, quality assurance and utilization data, character, mental condition, physical condition, alcohol or chemical dependency diagnosis and treatment, ethics, behavior, or any other matter reasonably having a bearing on my qualifications for Participation in, or with, the Entity. I authorize my current and past professional liability carrier(s) to release my history of claims that have been made and/or are currently pending against me. I specifically waive written notice from any entities and individuals who provide information based upon this Authorization, Attestation and Release.

Authorization of Release and Exchange of Disciplinary Information. I hereby further authorize any third party at which I currently have participation or had Participation and/or each third party's agents to release "Disciplinary Information," as defined below, to the Entity and/or its Agent(s). I hereby further authorize the Agent(s) to release Disciplinary information about any disciplinary action taken against me to its participating Entities at which I have Participation, and as may be otherwise required by law. As used herein, "Disciplinary Information" means information concerning (i) any action taken by such health care organizations, their administrators, or their medical or other committees to revoke, deny, suspend, restrict, or condition my Participation or impose a corrective action plan; (ii) any other disciplinary action involving me, including but not limited to, discipline in the employment context; or (iii) my resignation prior to the conclusion of any disciplinary proceedings or prior to the commencement of formal charges, but after I have knowledge that such formal charges were being (or are being) contemplated and/or were (or are) in preparation.

Release from Liability. I release from all liability and hold harmless any Entity, its Agent(s), and any other third party for their acts performed in good faith and without malice unless such acts are due to the gross negligence or willful misconduct of the Entity, its Agent(s), or other third party in connection with the gathering, release and exchange of, and reliance upon, information used in accordance with the Authorization, Attestation and Release. I further agree not to sue any Entity, any Agent(s), or any other third party for their acts, defamation or any other claims based on statements made in good faith and without malice or misconduct of such Entity, Agent(s) or third party in connection with the credentialing process. This release shall be in addition to, and in no way shall limit, any other applicable immunities provided by law for peer review and credentialing activities. In this Authorization, Attestation and Release, all references to the Entity, its Agent(s), and/or other third party include their respective employees, directors, officers, advisors, counsel, and agents. The Entity or any of its affiliates or agents retains the right to allow access to the application information for purposes of a credentialing audit to customers and/or their auditors to the extent required in connection with an audit of the credentialing processes and provided that the customer and/or their auditor executes an appropriate confidentiality agreement. I understand and agree that this Authorization, Attestation and Release is irrevocable for any period during which I am an applicant for Participation at an Entity, a member of an Entity's medical or health care staff, or a participating provider of an Entity. I agree to execute another form of consent if law or regulation limits the application of this irrevocable authorization. I understand that my failure to promptly provide another consent may be grounds for termination or discipline by the Entity in accordance with the applicable bylaws, rules, and regulations, and requirements of the Entity, or grounds for my termination of Participation at or with the Entity. I agree that information obtained in accordance with the provisions of this Authorization, Attestation and Release is not and will not be a violation of my privacy.

I certify that all information provided by me in my application is current, true, correct, accurate and complete to the best of my knowledge and belief, and is furnished in good faith. I will notify the Entity and/or its Agent(s) within 10 days of any material changes to the information (including any changes/challenges to license, DEA, insurance, malpractice claims, NPDB/HIPDB reports, discipline, criminal convictions, etc.) I have provided in my application or authorized to be released pursuant to the credentialing process. I understand that corrections to the application are permitted at any time prior to a determination of Participation by the Entity, and must be submitted online or in writing, and must be dated and signed by me (may be a written or an electronic signature). I acknowledge that the Entity will not process an application until they deem it to be a complete application and that I am responsible to provide a complete application and to produce adequate and timely information for resolving questions that arise in the application process. I understand and agree that any material misstatement or omission in the application may constitute grounds for withdrawal of the application from consideration; denial or revocation of Participation; and/or immediate suspension or termination of Participation. This action may be disclosed to the Entity and/or its Agent(s). I further acknowledge that I have read and understand the foregoing Authorization, Attestation and Release and that I have access to the bylaws of applicable medical staff organizations and agree to abide by these bylaws, rules and regulations. I understand and agree that a facsimile or photocopy of this Authorization, Attestation and Release shall be as effective as the original.

Signature* ______________________ Name (print)* ______________________

Date Signed* ______________________

*required response

No response may cause processing delays and require follow-up