BlueCross BlueShield of Illinois

Ancillary Credentialing Application

To apply for ancillary network participation, complete this form and submit with the required supporting documentation for your provider type. Failure to submit all required information will result in application denial.

Instructions

1. All fields are required. Complete this form in its entirety, including signature and date.
2. Gather all necessary required supporting documentation for your provider type as listed on the **Ancillary Credentialing Checklist**.
3. Submit your completed form and supporting documentation as noted below.

For these provider types:	Email the application and supporting documentation to:
• Durable medical equipment • Home infusion therapy • Orthotics and prosthetics	**Standard Ancillary Contracting**
• Behavioral health • Birthing centers • Coordinated home care • Freestanding ambulatory surgery centers • Freestanding dialysis • Hospice • Skilled nursing facility • Specialized mental health rehab facility – Medicaid only • Supportive living facility – Medicaid only	**Ancillary Facility Contracting**

We'll assign a case number once we receive all required information. If approved, we'll email you a contract for participation in the ancillary networks for which you qualify.

Type of Request

Select one:	☐ Freestanding	☐ Hospital based	☐ Part of a hospital system

Select one:	☐ Ambulatory surgery center (Submit roster of ASC physicians and surgeons on staff and joint venture relationship, if applicable)	☐ Durable medical equipment	☐ Skilled nursing facility
	☐ Behavioral Health	☐ Home infusion	☐ Skilled nursing facility (Type 63)
	☐ Coordinated home care	☐ Hospice	☐ Specialized mental health rehab facility
	☐ Dialysis	☐ Orthotics and prosthetics	☐ Supportive living facility

Provider Information and Questionnaire

1. Provider name _____
   Address_____ City _____ State _____ ZIP _____County _____
   Phone _____ Fax _____ Email _____
   Contracting entity (if applicable) _____
2. Payee name _____
   Address _____ City _____ State _____ ZIP _____
   Multiple locations? ☐ Yes ☐ No (If yes, complete a separate application and submit credentials for each location.)
3. Chief Executive Officer _____
4. Chief Financial Officer _____
5. Administrator/Director _____
6. Medical Director _____
7. Medical Director's National Provider Identifier _____
8. Medical Director's license number _____
9. Medical Director's board certification _____
10. Is the provider certified by Medicare? ☐ Yes ☐ No
11. Medicare provider number _____ Date of certification _____
12. Medicaid provider number _____ NPI _____
13. Federal tax identification number _____
14. State license number _____ Expiration date _____
15. Primary taxonomy? ☐ Yes ☐ No Selected taxonomy number _____ State _____
16. Is the provider accredited by an accrediting body? ☐ Yes ☐ No
    If yes, expiration date of accreditation _____ Accreditation provided by _____
17. Certificate of Insurance issued by _____Effective date _____ Expiration date _____
18. How is the provider organized? (Select one)
    ☐ Not-for-profit corporation ☐ For-profit corporation ☐ Partnership ☐ Sole proprietorship
    ☐ Other (Explain) _____
    a. If a corporation, attach a copy of the Articles of Incorporation and By-Laws. Label as 18a. ☐ Attached ☐ Does not apply
    b. If the organization is an unlisted corporation for profit, attach a sheet listing names, addresses and business affiliations of all stockholders and amounts of stock held by each. Label as 18b. ☐ Attached ☐ Does not apply
    c. If the organization is not a corporation, give the names, addresses and business affiliations of the owner or owners. Label as 18c. ☐ Attached ☐ Does not apply
    d. If other than a sole proprietorship, attach a copy of the ownership agreement. Label as 18d. ☐ Attached ☐ Does not apply
19. Are there health-related organizations or professionals associated with the organization through ownership or control? ☐ Yes ☐ No
20. Was provider previously contracted with BCBSIL under another name or ownership? ☐ Yes ☐ No (If yes, please provide the previous owner's name, Tax ID and NPI: _____)
21. Does the provider have any functions, activities or services being used offshore? ☐ Yes ☐ No
    If yes, what activities?_____
22. Select populations you have experience treating: (Select all that apply)
    ☐ Homeless ☐ HIV/AIDS ☐ Physical disabilities ☐ Chronic illness
    ☐ Serious mental illness ☐ Deafness or hard-of-hearing ☐ Blindness or visual impairment
23. Are the following standards in accordance with the Americans with Disabilities Act?
    Site accessible ☐ Yes ☐ No Parking accessibility ☐ Yes ☐ No Exterior building ☐ Yes ☐ No
    Interior building ☐ Yes ☐ No Exam table ☐ Yes ☐ No Exam room ☐ Yes ☐ No
    Office reception area ☐ Yes ☐ No Restroom ☐ Yes ☐ No Scale ☐ Yes ☐ No
    Close proximity to public transportation ☐ Yes ☐ No
24. Hours of operation: Sun _____ Mon _____ Tues _____ Wed _____ Thu _____ Fri _____ Sat _____
25. Languages spoken _____ 26. Language line interpreter? ☐ Yes ☐ No

Signature and Attestation

I confirm that all the above information is true.

Application prepared by:

Name _____

Signature _____ Date _____

Title _____ Email _____

Credentialing contact:

Name _____ Email _____