Provider Application

For use by Physicians and Independent Health Care Professionals

BCBSF Provider Number: _____

HCFA UPIN #: _____

NPI #: _____

PURPOSE:

This Provider Application will be used for assigning a provider number for Blue Cross and Blue Shield of Florida, Inc. and/or Health Options, Inc. and requests for network participation. Please follow the instructions carefully and provide current information to avoid delays in processing.

INSTRUCTIONS FOR COMPLETION:

A. Clearly print or type information in each block. Complete each section entirely, indicate NOT APPLICABLE (N/A) where necessary.

B. Attach **ALL** required documentation and credentials to the application. The application **will not** be processed without the appropriate documents.

- License(s)
- Registration(s)
- Certification(s)/Accreditation(s)
- Certificate of Insurance

C. Additional information can be attached on a separate sheet of paper.

D. Keep a copy of the completed application for your records.

E. The original application with attachments should be returned in the self-addressed envelope provided.

INCOMPLETE APPLICATIONS WILL BE RETURNED

PDSI
P.O. Box 41109
Jacksonville, Florida 32203-1109

ALL REFERENCES TO LICENSURE MUST BE TO A CURRENT FLORIDA STATE LICENSE WITH THE LICENSE NUMBER AND EFFECTIVE DATE CLEARLY READABLE.

Provider Application

BCBSF Provider Number: _____

GENERAL INFORMATION

Provider Name (First, MI, Last)		E-mail address
Office Address	County	Telephone Number ( ) Fax Number ( )
Billing Address (If different from above)	County	Contact Person Telephone Number ( )

GENERAL OFFICE INFORMATION

Office Manager/Credentialing Contact (First, MI, Last)	Telephone Number ( ) Fax Number ( )

Languages Spoken by Office Staff

Please list all languages spoken by staff, in order of fluency:

1. _____ 4. _____ American Sign Language ❍ Yes ❍ No

2. _____ 5. _____

3. _____ 6. _____

Office Hours

Day	Start (A=AM/P=PM)	End (A=AM/P=PM)
Monday		
Tuesday		
Wednesday		
Thursday		
Friday		
Saturday		
Sunday		

24/7 Phone Coverage ❍ Yes ❍ No If yes: ❍ Answering Service ❍ Voicemail with other instructions

Appointment Scheduling Phone Number: _____

Are there any practice limitations? ❍ Yes ❍ No If yes: ❍ Male only ❍ Female only ❍ None

Age limitations: _____ Minimum _____ Maximum

BCBSF Provider Number: _____

PROVIDER INFORMATION

Gender: ❍ Male ❍ Female | Date of Birth | Social Security Number

For EEOC compliance requirements only, please indicate the following:

❍ Caucasian ❍ African American ❍ Hispanic ❍ American Indian or Alaskan Native ❍ Asian or Oriental

❍ Other _____

List Non-English languages spoken by provider in order of fluency:

1. _____ 4. _____ American Sign Language ❍ Yes ❍ No

2. _____ 5. _____

3. _____ 6. _____

LICENSES - REGISTRATIONS - CREDENTIAL

Note: Copies of these documents must be submitted with this application.

❍ MD ❍ DO ❍ DC ❍ DPM ❍ DMD ❍ DDS ❍ PhD ❍ OD
❍ Independent Health Care Provider (Social Worker, Physical Therapist, etc.)

Type of practice: (Select One Only) ❍ Solo ❍ Single Specialty Group ❍ Multi-Specialty Group

Name of Group: (if applicable) _____

Florida Medical License Number	Original Issue Date	Expiration Date	Federal Tax ID Number

DEA Number	Expiration Date	Full Schedule? ❍ Yes ❍ No	If no, explain:

Note: If you have ever practiced in another state, please list state(s), years and license number(s) below.

EDUCATION

Medical School

School Location | Year of Graduation

Hospital Internship

Location | Date of Completion

Residency Fellowships

Location | Date of Completion

1.

2.

BCBSF Provider Number: _____

SPECIALTY BOARD CERTIFICATION

List certifying Board(s) (i.e., ABMS, AOA, etc.). **Note:** A copy of all current Board Certification(s) is required (if Board Certified). Information provided will be used for specialty designation in various provider directories.

Primary Specialty	Secondary Specialty
Board Certified? ❍ Yes ❍ No Exp. Date: _____	Board Certified? ❍ Yes ❍ No Exp. Date: _____
Board Qualified? ❍ Yes ❍ No	Board Qualified? ❍ Yes ❍ No

Practicing Specialty? (If different from Primary Specialty)

HOSPITAL AFFILIATIONS ❍ YES ❍ NO

Note: If yes, please indicate below the names of hospitals where you have active admitting privileges. Please list the primary affiliation first.

Hospital Name

1. _____ 3. _____

2. _____ 4. _____

Hospital Covering Arrangement

If you do not have admitting privileges, please provide below the name of the admitting covering physician and hospital.

Dr. _____ Hospital Name _____

PROFESSIONAL LIABILITY INSURANCE COVERAGE ❍ YES ❍ NO

Current Malpractice Insurance Carrier Name

Limits of Liability	Expiration Date	Policy Number

** If liability coverage has not been obtained, please attach a statement regarding what arrangements are in place to meet state requirements regarding financial responsibility.*

Federal Tort ❍ Yes ❍ No Sovereign Immunity ❍ Yes ❍ No Letter of Credit ❍ Yes ❍ No

Please provide a copy of the federal tort, Sovereign immunity or letter of credit.

WORK HISTORY

Include a chronological work history for the past 5 years. Must include (MMDDYY)

Practice/Employer's Name

Address Start Date (MMDDYY) End Date (MMDDYY)

Practice/Employer's Name

Address Start Date (MMDDYY) End Date (MMDDYY)

Practice/Employer's Name

Address Start Date (MMDDYY) End Date (MMDDYY)

BCBSF Provider Number: _____

WORK HISTORY GAPS ❍ YES ❍ NO

Note: Include an explanation of all gap(s) six (6) months or greater.

Gap(s) explanation:

Start Date: _____ End Date: _____

Gap(s) explanation:

Start Date: _____ End Date: _____

DISCLOSURE QUESTIONS

1. Has your license to practice in your profession ever been denied, suspended, revoked, restricted voluntarily surrendered or have you ever been subject to a consent order probation or any conditions or limitations by any state licensing board or professional association?	❍ Yes	❍ No
2. Have you ever received a reprimand or been fined by any state licensing board?	❍ Yes	❍ No
3. Have you ever had your Federal DEA denied, suspended, revoked, restricted, denied renewal or voluntarily relinquished?	❍ Yes	❍ No
4. Have you ever been subject to inquiries (including investigation or notice of intent to investigate) and or any actions with respect to your admitting staff privileges in any hospital or participation in any HMO or other managed care program/health care entity?	❍ Yes	❍ No
5. Have you ever been subject to sanctions or restrictions on receipt of payment from Medicare or Medicaid?	❍ Yes	❍ No
6. Have any felony charges ever been brought against you?	❍ Yes	❍ No
7. Have you ever been subject to peer review hearings or findings?	❍ Yes	❍ No
8. Have there been over the past five years or, currently pending, any malpractice claims, suits, settlements or arbitration proceedings involving your professional medical practice? If yes, provide a full explanation including status and amounts of any settlements and/or adverse judgments at the end of this application.	❍ Yes	❍ No

If the answer is YES to any one of the above, attach a full explanation to include resolution and/or current status.

Malpractice Claim Explanation

Date of Claim: Date of Settlement: Amount of Settlement:

Malpractice Claim Explanation

Date of Claim: Date of Settlement: Amount of Settlement:

Malpractice Claim Explanation

Date of Claim: Date of Settlement: Amount of Settlement:

BCBSF Provider Number: _____

HEALTH STATUS

1. Do you currently have a physical or mental health condition that currently affects, or could reasonably affect your ability to perform professional or medical practice duties appropriately? ❍ Yes ❍ No

2. Are you currently engaged in illegal use of chemical substances, or are you chemically dependent on alcohol, drugs or illegal substances? ❍ Yes ❍ No

3. Are you currently under contract with the Professionals Resource Network? If yes, please provide a current copy of the PRN letter. ❍ Yes ❍ No

Please provide a full explanation on any YES answers above.

REQUIRED ATTACHMENTS (Read this section carefully)

Attach current photocopies of:

1. Florida License
2. Drug Enforcement Agency License
3. Specialty Board Certificate(s)
4. Federal Tort or Sovereign Immunity Letter, or Letter of Credit
5. Certificate of Insurance (current)
6. Curriculum Vitae
7. Explanation for all "yes" answers (Under Disclosures/Health Status sections)

ATTESTATION

I HEREBY CERTIFY that the preceding information is true, complete and correct.* I give permission to Blue Cross and Blue Shield of Florida and its affiliates to contact any and all persons or entities to verify these facts. I agree there shall be no liability on the part of, and no action for damages shall arise against, Blue Cross and Blue Shield of Florida or its affiliates, its representatives, or any individuals or entities providing information in good faith related to the evaluation or verification of the information contained in this application. I agree to maintain active admitting and staff privileges at a Blue Cross and Blue Shield of Florida hospital, if applicable. I attest to having either current malpractice insurance or I have attached a statement regarding arrangements for meeting state, financial responsibility requirements. I also certify that I hold a full, unrestricted license to practice medicine in the state in which I reside. I will immediately inform Blue Cross and Blue Shield of Florida of any changes to the above information.

*I acknowledge and agree that any contract that may be entered into by Blue Cross and Blue Shield of Florida and/or any affiliate based on this application may, at the option of Blue Cross and Blue Shield of Florida, be deemed void and ineffective if any of the preceding information is not complete, true and correct.

Signature of Provider: _____ Date: _____