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# ENROLLMENT APPLICATION
# REQUIRED DOCUMENTATION CHECKLIST

Please submit current copies of ALL of the documentation listed below. Any missing or inaccurate information will delay the enrollment process.

| | |
|---|---|
| ☐ | Application for Practitioner Enrollment<br>• Complete all sections and especially the *required* fields, Social Security number and Taxonomy Code.<br>• All addresses:<br>  • Primary Office<br>  • Remittance<br>  • Correspondence<br>  • Medical Record |
| ☐ | A Council for Affordable Quality Health Care (CAQH) number is required. You can self-register on the CAQH website (www.caqh.org). Please ensure that your CAQH information is completed and released to us with the most up-to-date information. |
| ☐ | W-9 Request for Taxpayer Identification Number and Certification |
| ☐ | Proof of Malpractice (liability) insurance<br>- Minimum amount of $1 million per occurrence and $3 million aggregate. Ensure certificate has effective date, (current) expiration date, and coverage amounts. |
| ☐ | Behavioral Health (BH) Certification |
| ☐ | Attestation for LMHC, LMFT, and LCSW |
| ☐ | (Current) Curriculum Vitae (CV) |

We will notify you when your application has been approved. Upon notification, you will be considered a participating provider in our network. Prior to receiving this notification, you are **not** considered in-network.

Credentialing applications are usually processed within 90 days of receipt. Please ensure that applications are completed in their entirety, signed, and all supporting documentation included.

# Application for Practitioner Enrollment-C

To begin the enrollment process, please complete all information as it applies to your specialty. Information that does not apply to your specialty may be left blank.

***Please attach the W-9 form and a copy of the malpractice (liability) insurance. Enrollment will not be processed without this documentation.***

| | | |
|---|---|---|
| *Are you enrolling in the Health Plan due to COVID-19 pandemic?* ☐ Yes ☐ No | | |
| Last Name: | First Name: | Middle Initial: |
| Date of Birth: | **Social Security # *(required)*:** | Gender: ☐ Male ☐ Female |
| **CAQH Provider ID *(required)*:** | Language(s) spoken other than English: | |

Applying as: ☐ PCP ☐ Specialist ☐ Allied/Consulting Health Professional

| | | |
|---|---|---|
| Individual NPI #: | Group Name (*If Applicable*): | |
| Tax ID #: | Group Tax ID #: | Group NPI #: |
| Primary Specialty: | **Taxonomy Code *(required)*:** | License # & State: |
| Second Specialty: | **Taxonomy Code *(required)*:** | DEA # & State: |
| **Medicaid # *(required)* :** **To be enrolled in Medicaid products, an *active* Medicaid ID number is required** | | Medicare #: |

***Select only one provider type:***

***Non–Credentialed***

☐ Anesthesiologist * ☐ CRNA ☐ Emergency Room ☐ Hospitalist ☐ Locum Tenens ☐ Pathologist ☐ CDE (affiliated with Physician Group or Hospital) ☐ RD (affiliated with Physician Group or Hospital)

Requested Effective Date: _____ / _____ / _____ *(non-credentialed providers only—**30-day backdate only**)*

[We will notify you when your application has been approved. Upon notification, you will be considered a participating provider in our network. Prior to receiving this notification, you are **not** considered in-network.]

***If you selected Anesthesiologist*, Emergency Room, Hospitalist, Locum Tenens, Pathologist, CRNA, CDE or RD, you must complete the disclosure questions on the last page.***

*** Do you provide Pain Management?** ☐ Yes ☐ No ***If Yes, you must be credentialed.***

***Credentialed***

(Credentialed specialties are usually processed within 90 days of receipt.)

☐ Acupuncturist (LAC)
☐ Audiologist (AUD)
☐ Certified Diabetic Educator (CDE) [1]
☐ Certified Nurse Midwife (CNM)
☐ Certified Nurse Midwife—Home Birth (CNM)
☐ Clinical Psychologist (PHD/PSYD)
☐ Doctor of Chiropractic (DC)
☐ Doctor of Podiatric Medicine (DPM)
☐ Enterostomal Therapy
☐ Licensed Behavioral Analyst (ABA)
☐ Licensed Clinical Social Worker (LCSW)
☐ Licensed Marriage & Family Therapist (LMFT)
☐ Licensed Mental Health Counselor (LMHC) [2]
☐ Medical Doctor (e.g. MD/MBBS/BMED etc.)
☐ Nurse Practitioner, Primary Care
☐ Nurse Practitioner, Psychiatry
☐ Occupational Therapist (OT)
☐ Optometrist (OD)
☐ Oral Maxillofacial Surgery (DMD)
☐ Osteopathic Doctor (DO)
☐ Physical Therapist (PT)
☐ Registered Dietician (RD) [1]
☐ Speech Pathologist (SP/SLP)

[1] *Independent* [2] *Not facility based must complete page 4*

**Experienced HIV/AIDS Provider:** ☐ Yes ☐ No

Please provide the required addresses: Primary Office, Correspondence, Remittance, and Medical Records. Each address can be the same or different, but ***must*** be identified as a valid United States Postal Service mailing address. If **PO BOX** information is used, the corresponding City, State and ZIP Code for the

**Address A**

| | | | | | |
|---|---|---|---|---|---|
| ○ Primary Office | ○ Additional Office | ○ Correspondence | ○ Remittance | ○ Medical Record | |
| Address: | | Ste: | City: | State: | ZIP Code: |
| **Phone *(required)*:** | | Fax: | | | |
| **Handicap accessible *(required)*:** ☐ Yes ☐ No | | Public Transportation: ☐ Yes ☐ No | | | |
| **List address in directory *(required)*:** ☐ Yes ☐ No | | Provider is Hospitalist at this address: ☐ Yes ☐ No | | | |

**Address B**

| | | | | | |
|---|---|---|---|---|---|
| ○ Primary Office | ○ Additional Office | ○ Correspondence | ○ Remittance | ○ Medical Record | |
| Address: | | STE: | City: | State: | ZIP Code: |
| **Phone *(required)*:** | | Fax: | | | |
| **Handicap accessible *(required)*:** ☐ Yes ☐ No | | Public Transportation: ☐ Yes ☐ No | | | |
| **List address in directory *(required)*:** ☐ Yes ☐ No | | Provider is Hospitalist at this address: ☐ Yes ☐ No | | | |

**Address C**

| | | | | | |
|---|---|---|---|---|---|
| ○ Primary Office | ○ Additional Office | ○ Correspondence | ○ Remittance | ○ Medical Record | |
| Address: | | STE: | City: | State: | ZIP Code: |
| **Phone *(required)*:** | | Fax: | | | |
| **Handicap accessible *(required)*:** ☐ Yes ☐ No | | Public Transportation: ☐ Yes ☐ No | | | |
| **List address in directory *(required)*:** ☐ Yes ☐ No | | Provider is Hospitalist at this address: ☐ Yes ☐ No | | | |

Note: If you have already completed your application with CAQH, please ensure that you have authorized all applicable organizations to access your data. Using the CAQH Universal Credentialing DataSource does not grant participation or constitute applying for participation with the health plan. If applicable, contact the health plan directly to request contracting information.

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# Application for Practitioner Enrollment-C

What hours are you available to see patients?

| Address A: | | |
|---|---|---|
| | Office Start | Office End |
| Monday | | |
| Tuesday | | |
| Wednesday | | |
| Thursday | | |
| Friday | | |
| Saturday | | |
| Sunday | | |

| Address B: | | |
|---|---|---|
| | Office Start | Office End |
| Monday | | |
| Tuesday | | |
| Wednesday | | |
| Thursday | | |
| Friday | | |
| Saturday | | |
| Sunday | | |

| Address C: | | |
|---|---|---|
| | Office Start | Office End |
| Monday | | |
| Tuesday | | |
| Wednesday | | |
| Thursday | | |
| Friday | | |
| Saturday | | |
| Sunday | | |

***Have you, your agent, or managing employee ever been convicted of a crime relating to Medicare, Medicaid or any government health program or the furnishing of, or billing for, medical care, services, or supplies or which is considered an offense involving theft or fraud or an offense against public administration or against public health and morals?*** Yes ☐ No ☐ If Yes, please provide the following:
Name/Title, DOB, Address, SSN:

| Office/Credentialing Contact name (*please print or type)*: | Phone: |
|---|---|
| Office/Credentialing Contact email address (*please print or type)*: : | |

**Include the completed form along with a copy of the W-9 and malpractice (liability) insurance, and mail, email, or fax to:**

| | |
|---|---|
| Address: | Univera Healthcare, Attn: Provider Relations, 205 Park Club Lane, Buffalo, NY 14221 |
| Fax number: | 716-857-4578 |

# Disclosure Questions for Non-Credentialed Practitioners

**All questions must be completed by the following practitioners:**
**Anesthesiologist, Emergency Room, Hospitalist, Locum Tenens, Pathologist, CRNA,**
**[Certified Diabetic Educator and Registered Dietician affiliated with Physician Group or Hospital]**

1. ☐ Yes ☐ No ☐ NA Has your license, registration or certification to practice in your profession ever been voluntarily or involuntarily relinquished, denied, suspended, revoked, restricted, or have you ever been subject to a fine, reprimand, consent order, probation or any conditions or limitations by any state or professional licensing, registration or certification board?

2. ☐ Yes ☐ No ☐ NA Have your clinical privileges or medical staff membership at any hospital or health care institution (either voluntarily or involuntarily) ever been denied, suspended, revoked, restricted, denied renewal or subject to probationary or to other disciplinary conditions (for reasons other than non-completion of medical record when quality of care was not adversely affected), or have proceedings toward any of those ends been instituted or recommended by any hospital or health care institution, medical staff or committee or

3. ☐ Yes ☐ No ☐ NA Have you ever been terminated for cause or not renewed for cause from participation, or been subject to any disciplinary action by any managed care organizations or health plans (including HMOs, PPOs, or provider organizations such as independent practice associations or private health organizations)?

4. ☐ Yes ☐ No ☐ NA Have your federal Drug Enforcement Administration and/or state controlled dangerous substances (CDS) certificates(s) or authorization(s) ever been challenged, denied, suspended, revoked, restricted, denied renewal, or voluntarily or involuntarily relinquished?

5. ☐ Yes ☐ No ☐ NA Are you currently or have you ever been the subject of an investigation by any hospital, licensing authority, DEA or CDS-authorizing entities, education or training program, Medicare or Medicaid program, regulatory agency, or any other private, federal or state health program or been a defendant in any civil action that is reasonably related to your qualifications, competence, functions or duties as a medical professional for alleged fraud, an act of violence, child abuse or a sexual offense or sexual misconduct?

6. ☐ Yes ☐ No ☐ NA To your knowledge, has information pertaining to you ever been reported to the National Practitioner Databank or Healthcare Integrity and Protection Data Bank?

7. ☐ Yes ☐ No ☐ NA Has your professional liability coverage ever been cancelled, restricted, declined or not renewed by the carrier based on your individual liability history?

For any “Yes” response, please provide a detailed explanation on a separate sheet.

"I hereby attest that the above information is true and accurate to the best of my knowledge."

Provider Signature: _____ Date: _____

**Include the completed form along with a copy of the W-9 and malpractice (liability) insurance, and mail or fax to:**

| | |
|---|---|
| Address: | Univera Healthcare, Attn: Provider Relations, 205 Park Club Lane, Buffalo, NY 14221 |
| Fax number: | 716-857-4578 |

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**Attestation for:**
**Licensed Mental Health Counselor (LMHC)**
**Licensed Clinical Social Worker (LCSW)**
**Licensed Marriage & Family Therapist (LMFT)**

**Not for OMH or OASAS certified facility based counselors**

In accordance with Excellus BlueCross Blue Shield credentialing policies, including the credentialing/recredentialing criteria for Licensed Mental Health Counselors, and my participation agreement with Health Plan, I attest to the following:

| | |
|---|---|
| A. | I will practice within the scope of practice defined by the New York State Department of Education Office of Professions. |
| B. | I will clearly define in each client's notes:<br>1.) The full name of the medical doctor who is credentialed to establish the mental health or chemical use diagnosis I am using to bill with*, and<br>2.) The date this diagnosis was made, and<br>3.) The full name of the medical doctor I consult with in the respective member's mental health and or substance use treatment. * |
| C. | I will make my records available upon request for quality, compliance, auditing, billing or other purposes in accordance with the terms of my participation agreement with Health Plan. |
| D. | I will ensure my medical record documentation, including initial assessments, treatment plans, progress notes, and psychotherapy, appropriately align with the member's plan of care, and are readily available upon request. |
| E. | ☐ I am a LMHC, LCSW, LMFT with 6 years of post-graduate degree clinical practice experience under the supervision of a qualified licensed mental health professional. |
| F. | I am (select one or all that apply):<br>☐ A participating LMHC with Health Plan, practicing and being supervised by an employee of an OMH clinic. *<br>☐ A participating LMHC with Health Plan, practicing and being supervised in a practice in which the diagnosis and required supervision of cases is provided by an LCSW-R, PhD or Psychiatrist. *<br>☐ Employed by or co-located in a primary care office, in which the diagnosis is established by a Health Plan participating physician, physician's assistant or nurse practitioner. * |
| G. | I have read and fully understand my obligations under the Health Plan's Telemedicine and Telehealth Policy 1.01.49. |
| H. | I have read and fully understand my obligations under the Health Plan's Credentialing/Recredentialing Criteria Non-Physician Health Care Practitioner, Licensed Mental Health Counselor Policy, Licensed Marriage & Family Therapist, Licensed Clinical Social Worker. |

Print Name: _____ Date: _____

Signature: _____

* In accordance with the New York State Department of Education, Office of Professions, if an LMHC is continuously treating a client for mental health or substance use DSM diagnosis, the LMHC *must* have a medical doctor complete a medical evaluation and consultation to determine and advise the LMHC whether the member is in need of medical care, and if so, for what illness, diagnosis or treatment.

Include the completed form along with a copy of the W-9 and malpractice (liability) insurance, and mail or fax to:

| | |
|---|---|
| Address: | Univera Healthcare, Attn: Provider Relations, 205 Park Club Lane, Buffalo, NY 14221 |
| Fax number: | 716-857-4578 |

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# BEHAVIORAL HEALTH PROVIDERS (BH) Certification

## CONVERSION THERAPY

I _____ attest to the following:
[ *First Name, Middle Initial, Last Name* ]

☐ I am a mental health professional participating/seeking to participate in the Excellus BlueCross BlueShield provider network.

☐ I will not provide conversion therapy to minors or seek reimbursement from Excellus BlueCross BlueShield for such services.

☐ I understand that "conversion therapy" is defined as "any practice by a mental health professional that seeks to change an individual's sexual orientation or gender identity, including efforts to change behaviors, gender expressions, or to eliminate or reduce sexual or romantic attractions or feeling toward individuals of the same sex."

☐ I will comply with all other applicable laws, rules, regulations and Excellus BlueCross BlueShield policies regarding conversion therapy.

Print Name: _____ Date: _____

Signature: _____

| | |
|---|---|
| Address: | Univera Healthcare, Attn: Provider Relations, 205 Park Club Lane, Buffalo, NY 14221 |
| Fax number: | 716-857-4578 |