Provider Credentialing & Data Management Webinar

For the listening benefit of webinar attendees, we have muted all lines and will be starting our presentation shortly.

- This helps prevent background noise (e.g., unmuted phones or phones put on hold) during the webinar.
- This also means we are unable to hear you during the webinar.
- Please submit your questions directly through the webinar platform only.

How to submit questions:

- Open the Q&A feature at the bottom of your screen, type your question related to today's training webinar and hit "enter."
- Once your question is answered, it will appear in the "Answered" tab.
- All questions will be answered by the end of the webinar.

PROVIDER CREDENTIALING & DATA MANAGEMENT

February 2023

Melonie Martin
Provider Relations

Louisiana

Blue Cross Credentialing

We credential and recredential all practitioners and facilities that participate in our networks, and we partner with **Vantage Health Plan** and **symplrCVO** to conduct credentialing verification processes for our commercial and Blue Advantage networks.

Credentialing Overview

Joining Our Networks

There are two types of Blue Cross provider records a provider can obtain:

1. You may request network participation as a **participating provider**.

2. You may request just a provider record as a **non-participating provider** for the purpose of filing claims.

Participating vs. Non-participating Providers

Participating Provider

- Provider has entered into a contractual agreement with Blue Cross to provide covered services to our members.
- Payments are based on the provider's schedule of allowable charges.
- Provider may bill the member for any deductible, coinsurance, copayment and/or non-covered service. Provider agrees not to collect any amount over the allowable charge from the member.
- Payment goes directly to the participating provider.
- Participating providers see increased Blue Cross patient volume since members receive higher benefits when using network providers.
- Only participating providers are listed in our online provider directory featured on our corporate website (**www.bcbsla.com**).

Participating vs. Non-participating Providers

Non-participating Provider

- Provider has chosen not to sign a network agreement with Blue Cross.
- We establish a non-participating rate for covered services rendered by non-participating providers.
- The provider may balance bill the member for all amounts not paid by Blue Cross with the exception of services covered under the No Surprises Act.
- In most situations, Blue Cross payments for claims to a non-participating provider are sent directly to the member.
- Some members may have no benefits for services provided by non-participating providers without obtaining prior approval.
- Non-participating providers are **not** listed in our online provider directory.

Credentialing Overview for Participating Providers

- Since 1996, we have been dedicated to fully credentialing providers who apply for network participation.
- Our credentialing program is accredited by the Utilization Review Accreditation Commission (URAC).
- To participate in our networks, providers must meet certain criteria as regulated by our accreditation body and the Blue Cross Blue Shield Association.
- We credential professional and facility providers.
- Included on the next slides are brief overviews of our processes, criteria and requirements for providers to request network participation.

Credentialing Process

- The initial credentialing process can take up to 90 days after all required information is received.
- Providers will remain non-participating in our networks until a signed agreement is received by our contracting department.
- The credentialing committee approves credentialing twice per month.
- Network providers are recredentialed every three years from their last credentialing acceptance date.

Inquire about your initial credentialing status by contacting our Provider Credentialing & Data Management (PCDM) Department at **PCDMstatus@bcbsla.com**.

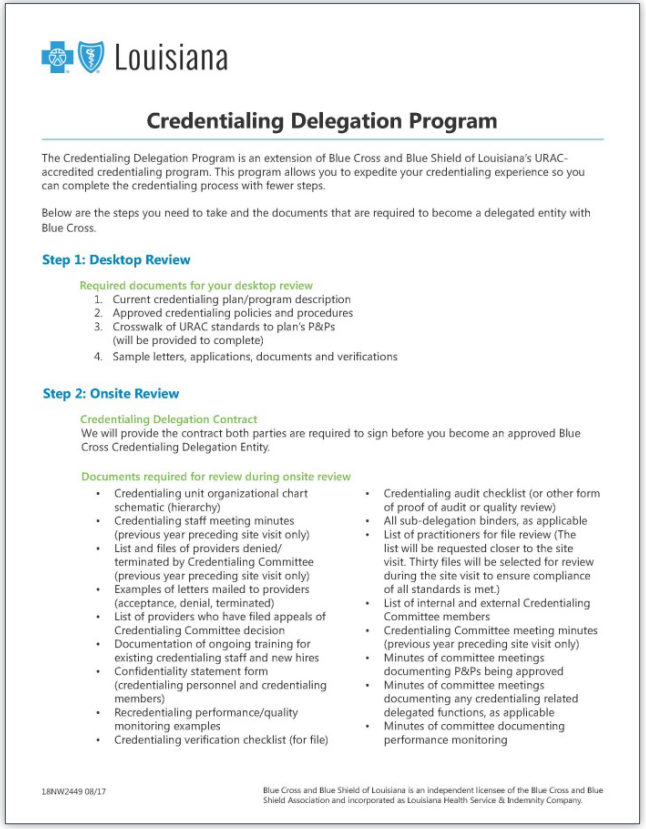
Credentialing Committee

The Credentialing Committee:

- Has the final authority to make decisions regarding provider participation.
- Provides guidance and suggestions for the credentialing process.
- Is made up of a diverse group of network providers from across the state with no other management role at Blue Cross.
- Includes multiple Blue Cross employees from Medical Management and Provider Credentialing & Data Management.

Credentialing Delegation Program

- The Credentialing Delegation Program is an extension of our accredited credentialing program.
- An approved delegation entity essentially credentials its own providers and sends the information to Blue Cross to create their provider records.
- This program allows you to expedite your credentialing experience so you can complete the Blue Cross credentialing process with fewer steps.
- Available to groups with 50 or more practitioners.
- After a provider group is approved as a delegation entity, it will not be necessary to submit provider applications to be set up in the Blue Cross system.
- The *Credentialing Delegation Program* guide explains the steps network provider groups must take and the documents required to become a delegated entity.
- If you have any questions about the Credentialing Delegation Program, please email **credentialing.delegation@bcbsla.com**.



Louisiana

Credentialing Delegation Program

The Credentialing Delegation Program is an extension of Blue Cross and Blue Shield of Louisiana's URAC-accredited credentialing program. This program allows you to expedite your credentialing experience so you can complete the credentialing process with fewer steps.

Below are the steps you need to take and the documents that are required to become a delegated entity with Blue Cross.

Step 1: Desktop Review

Required documents for your desktop review

1. Current credentialing plan/program description
2. Approved credentialing policies and procedures
3. Crosswalk of URAC standards to plan's P&Ps (will be provided to complete)
4. Sample letters, applications, documents and verifications

Step 2: Onsite Review

Credentialing Delegation Contract

We will provide the contract both parties are required to sign before you become an approved Blue Cross Credentialing Delegation Entity.

Documents required for review during onsite review

- Credentialing unit organizational chart schematic (hierarchy)
- Credentialing staff meeting minutes (previous year preceding site visit only)
- List and files of providers denied/ terminated by Credentialing Committee (previous year preceding site visit only)
- Examples of letters mailed to providers (acceptance, denial, terminated)
- List of providers who have filed appeals of Credentialing Committee decision
- Documentation of ongoing training for existing credentialing staff and new hires
- Confidentiality statement form (credentialing personnel and credentialing members)
- Recredentialing performance/quality monitoring examples
- Credentialing verification checklist (for file)
- Credentialing audit checklist (or other form of proof of audit or quality review)
- All sub-delegation binders, as applicable
- List of practitioners for file review (The list will be requested closer to the site visit. Thirty files will be selected for review during the site visit to ensure compliance of all standards is met.)
- List of internal and external Credentialing Committee members
- Credentialing Committee meeting minutes (previous year preceding site visit only)
- Minutes of committee meetings documenting P&Ps being approved
- Minutes of committee meetings documenting any credentialing related delegated functions, as applicable
- Minutes of committee documenting performance monitoring

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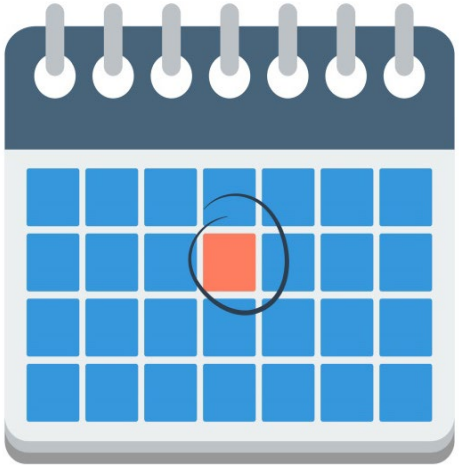
Blue Cross and Blue Shield of Louisiana is an independent licensee of the Blue Cross and Blue Shield Association and incorporated as Louisiana Health Service & Indemnity Company.

Effective Dates

For non-participating providers (requesting a provider record only)**:**

Presently, we allow non-participating effective dates up to two years back for providers who want a provider record only for filing claims.



Effective Dates

For participating providers:

We cannot retroactively allow network participation prior to a provider's credentialing date. Our accrediting organization strictly prohibits it. Effective dates are based on:

Delegation Program Providers	New Providers Not Credentialed	Providers Already Credentialed
The effective date for delegated providers is based on approval of the Credentialing Delegation spreadsheet by our Medical Director.	If you are eligible for reimbursement during credentialing (joining an existing contracted group), then it is one month prior to the date of receipt of application; **OR** If you are not eligible for reimbursement during credentialing, then it is the approved date by the Credentialing Committee **AND** the execution of your network agreement.	If the requested effective date on the Provider Update Request Form (Existing Providers Joining a New Provider Group) is within 90 days of the calendar date, then it will be that date, but not before the group's effective date. If the requested effective date on the Provider Update Request Form (Existing Providers Joining a New Provider Group) is greater than 90 days of the calendar date, then it will be 90 days from the day the information was received, but not before the group's effective date.

Reimbursement During Credentialing

Reimbursement During Credentialing applies to all professional provider types, when criteria are met.

Reimbursement During Credentialing will be granted to all professional providers **joining an existing contracted provider group**. This allows for in-network reimbursement on submitted claims during the credentialing process.

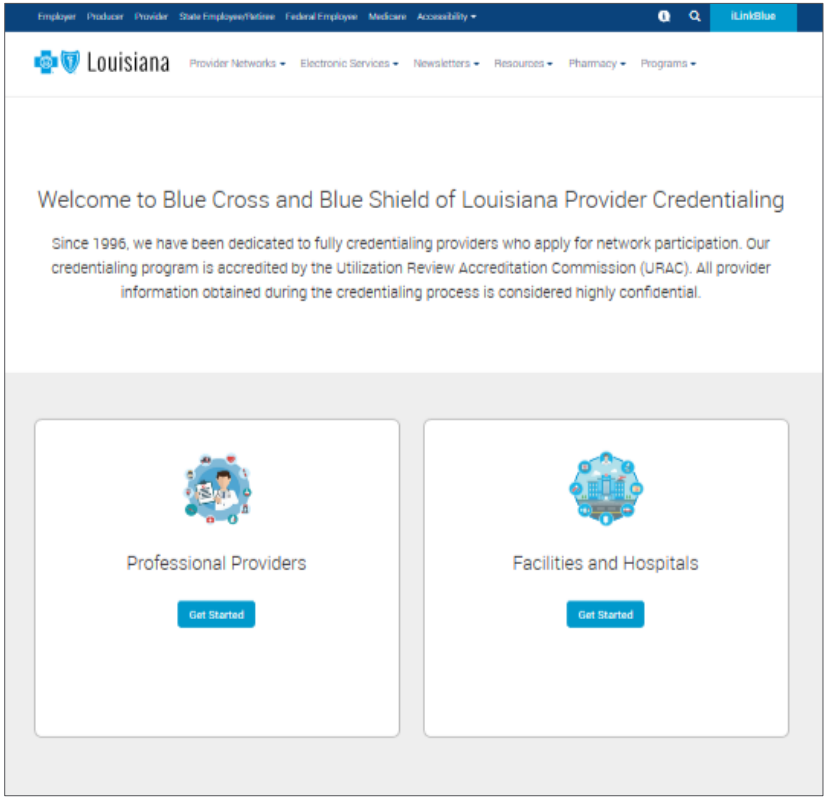
This provision does not apply for solo practitioners.

Providers should not file/submit claims until receiving a provider number letter from our PCDM Department notifying you of the Reimbursement During Credentialing effective date. If you have any questions about the Reimbursement During Credentialing Process, contact PCDM at 1-800-716-2299, option 2 or **PCDMstatus@bcbsla.com**.

More information can be found on our guide at **www.bcbsla.com/providers** >Resources >Forms >How to Request Reimbursement During Credentialing.

Finding Forms on Our Credentialing Webpage

To join our networks, you must complete and submit documentation to start the credentialing process or to obtain a provider record.



Go to the **Join Our Networks** page then, select **Professional Providers** or **Facilities and Hospitals** to find:

- Credentialing packets
- Quick links to the Provider Update Request Form
- Credentialing criteria for professional, facility and hospital-based providers

www.bcbsla.com/providers >Network Enrollment >Join Our Networks

Easily Complete Forms with DocuSign®

Credentialing packets:

- **Professional** (initial)
- **Facility** (initial)

Forms:

- **Provider Update Request Form** – to update information such as:
  - Demographic Information – for updating contact information.
  - Existing Providers Joining a New Provider Group – if you are joining an existing provider group or clinic or adding new providers to your group.
  - Add Practice Location – to add a practice location(s).
  - Remove Practice Location – to remove a practice location(s).
  - Tax Identification Number (TIN) Change – to change your Tax ID number.
  - Terminate Network Participation – to terminate existing network participation or an entire provider record.
  - EFT Term/Change Request – to change your electronic funds transfer (EFT) information or to cancel receiving payments via this method.
- **EFT Enrollment Form** – to begin receiving payments via electronic funds transfer (EFT).

After submitting your documents through DocuSign, please do not send via email.

Easily Complete Forms with DocuSign®

Complete, sign and submit applications and forms to the PCDM Department digitally with **DocuSign**.

This streamlines submissions by reducing the need to print and submit hardcopy documents, allowing for a more direct submission of information to Blue Cross.

It allows you to electronically upload support documentation and even receive reminder alerts to complete submission and confirm receipt.

What is DocuSign?

As an innovator in e-signature technology, DocuSign helps organizations connect and automate how various documents are prepared, signed and managed.


Louisiana

DocuSign® Guide

Blue Cross and Blue Shield of Louisiana is enhancing your provider experience by streamlining how you submit applications and forms to the Provider Credentialing & Data Management (PCDM) department. You can now complete, sign and submit many of our applications and forms digitally with DocuSign®, reducing the need to print and submit hardcopy documents. This allows for a more direct submission of information to Blue Cross. Through this enhancement, you can electronically upload support documentation and even receive alerts (reminding you to complete your application) and confirm receipts. Follow the steps below to access and complete your applications and forms with DocuSign®.

Step 1: Click the link for the needed Blue Cross form, then enter your initial information

There are two required recipients. The person completing the form must enter a name and email for both.

- "Form Completed By" - This recepient will complete all required fields with detailed information.
- "Provider" - This recepient provides final review and signature verifying that all information is correct and ready to submit to BCBSLA.

Once the information is entered for both, click the "BEGIN SIGNING" button.

Note: If the "Form Completed By" and "Provider" are the same person, enter the same name and email for each role.

BEGIN SIGNING

Step 2: Accept the Electronic Record and Signature Disclosure

- The person completing the form must review the Electronic Record and Signature Disclosure documents and consent to sign electronically.
- Select the checkbox "I agree to use Electronic Records and Signatures."
- Click "CONTINUE" to begin the signing process.

Note: To view and sign documents, the person completing this form must agree to conduct business electronically.

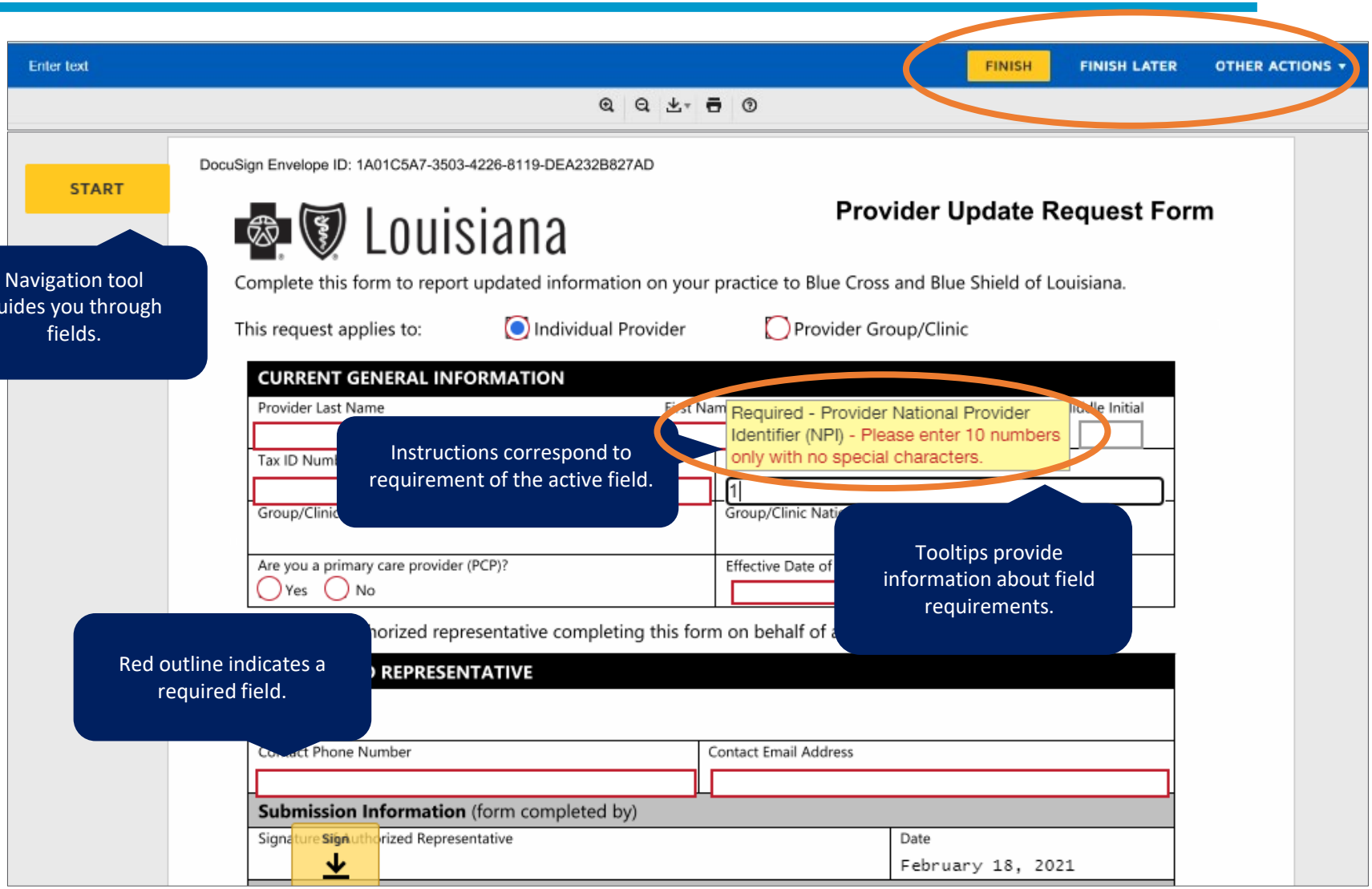
Please Review & Act on These Documents

DocuSign

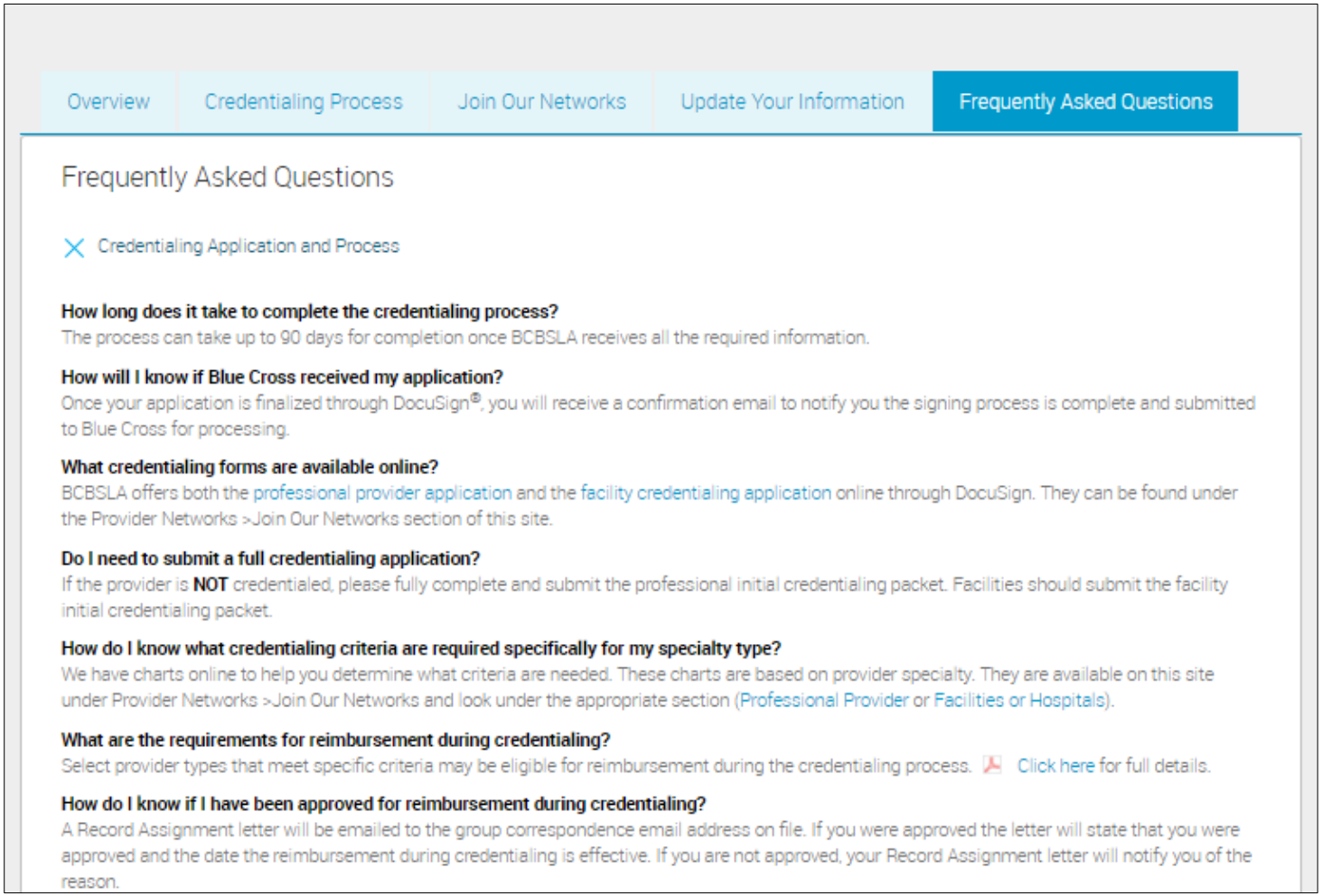
CONTINUE FINISH LATER OTHER ACTIONS

To help with this transition, we created a *DocuSign® Guide* that is available online at **www.bcbsla.com/providers** >Network Enrollment >Join Our Networks >Professional Providers/Facilities and Hospitals >Join Our Networks.

Easily Complete Forms with DocuSign®



Frequently Asked Questions



www.bcbsla.com/providers >Network Enrollment >Join Our Networks >Professional Providers/Facilities and Hospitals >Frequently Asked Questions

Initial Credentialing for Professional Providers

Credentialing Criteria for Professional Providers

The following professional provider types must meet certain criteria to participate in our networks:

- Acupuncturists
- Applied Behavioral Analysts (ABA)
- Audiologist
- Certified Nurse Midwife (CNM)
- Certified Registered Nurse Anesthetist (CRNA)
- Certified Registered Nurse First Assistants (CRNFA)
- Clinical Nurse Specialist (CNS)
- Doctor of Chiropractic (DC)
- Doctor of Osteopathic (DO)
- Doctor of Medicine (MD)
- Doctor of Podiatric Medicine (DPM)
- Doctor of Dental Surgery (DDS)
- Doctor of Medicine in Dentistry (DMD)
- Hearing Aid Dealer
- Licensed Addictive Counselor (LAC)
- Licensed Professional Counselor (LPC)
- Licensed Clinical Social Worker (LCSW)
- Nurse Practitioner (NP)
- Occupational Therapist (OT)
- Optometrist (OD)
- Physician Assistant (PA)
- Psychologist (PhD)
- Physical Therapist (PT)
- Registered Dietician & Nutritionist (RD)
- Registered Nurse First Assistants (RNFA)
- Speech-Language Pathologist & Audiologist (SLP)

View the *Credentialing Criteria* for these professional provider types at **www.bcbsla.com/providers** >Network Enrollment >Join Our Networks >Professional Providers >Credentialing Process.

Telehealth Only Providers

Our credentialing policy includes guidance for the provision of telehealth services to our members in the following scenarios:

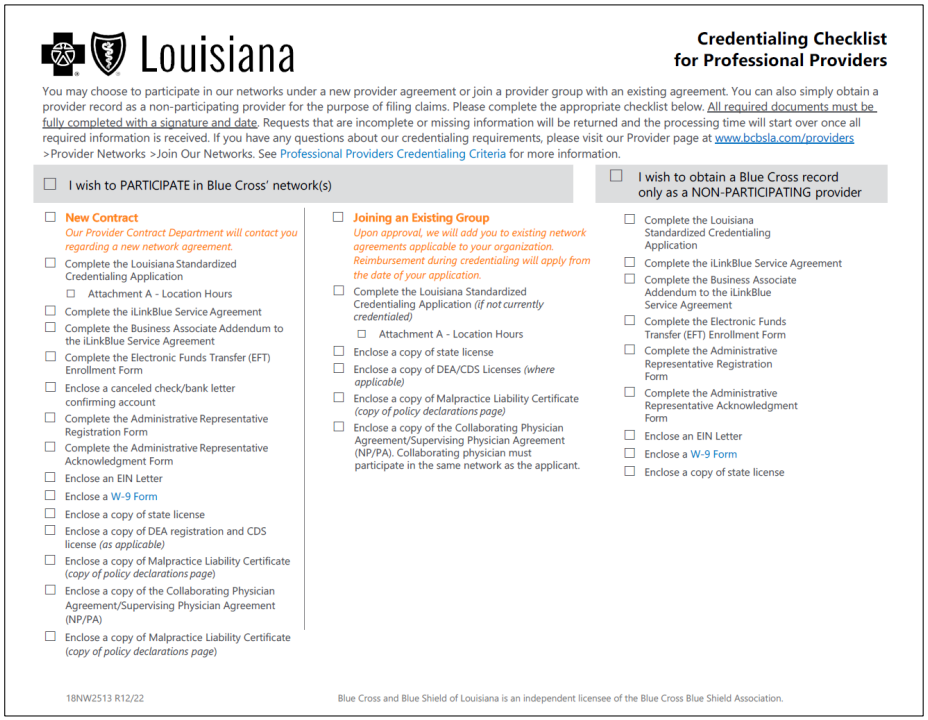
- Louisiana-based, in-network provider
  - Must be in process of or have completed credentialing/contracting to participate in our network.
- Out-of-state provider with Louisiana-based practice
  - Must be employed or affiliated with a Louisiana-based group or entity.
  - Must have a Louisiana State license as required for their specialty.
  - If not licensed in the state of Louisiana, then a Telehealth Permit issued by the Louisiana Board of Medical Examiners (LSBME) is required (includes the condition of maintaining affiliation with a Louisiana based practice or entity).
- Out-of-state provider without Louisiana-based practice affiliations
  - Must be credentialed/contracted with another Blue Plan.
  - Can be individually credentialed/contracted or part of a group or entity that is credentialed/contracted with the out-of-state Blue Plan.
  - Claims filing is based on where the provider is physically located when rendering the telehealth service.
- National telehealth solution/vendor
  - A national telehealth solution contracts directly with Blue Cross to offer our members telehealth services accessible in the home plan region and outside of it to ensure access while members are out of their home plan area.

Hospital-based Providers

- A hospital-based provider is defined as a provider that **only** sees patients as a result of their being admitted or directed to the hospital.
- The classification as a hospital-based provider applies for the hospital location only and NOT for any other practice locations outside the hospital.
- Hospital-based providers can be allowed to participate in our networks without credentialing requirements. We do not list those providers in the directory and allow the hospital's credentialing to stand.
- Reimbursement effective date is based on the provider's start date.

A provider is NOT considered hospital-based if you have patients referred directly to you from another physician or organization or if the member can make an appointment with the physician.

Required Documentation



Louisiana

Credentialing Checklist for Professional Providers

You may choose to participate in our networks under a new provider agreement or join a provider group with an existing agreement. You can also simply obtain a provider record as a non-participating provider for the purpose of filing claims. Please complete the appropriate checklist below. All required documents must be fully completed with a signature and date. Requests that are incomplete or missing information will be returned and the processing time will start over once all required information is received. If you have any questions about our credentialing requirements, please visit our Provider page at www.bcbsla.com/providers >Provider Networks >Join Our Networks. See Professional Providers Credentialing Criteria for more information.

☐ I wish to PARTICIPATE in Blue Cross' network(s)

☐ **New Contract**
Our Provider Contract Department will contact you regarding a new network agreement.
- ☐ Complete the Louisiana Standardized Credentialing Application
  - ☐ Attachment A - Location Hours
- ☐ Complete the iLinkBlue Service Agreement
- ☐ Complete the Business Associate Addendum to the iLinkBlue Service Agreement
- ☐ Complete the Electronic Funds Transfer (EFT) Enrollment Form
- ☐ Enclose a canceled check/bank letter confirming account
- ☐ Complete the Administrative Representative Registration Form
- ☐ Complete the Administrative Representative Acknowledgment Form
- ☐ Enclose an EIN Letter
- ☐ Enclose a W-9 Form
- ☐ Enclose a copy of state license
- ☐ Enclose a copy of DEA registration and CDS license *(as applicable)*
- ☐ Enclose a copy of Malpractice Liability Certificate *(copy of policy declarations page)*
- ☐ Enclose a copy of the Collaborating Physician Agreement/Supervising Physician Agreement (NP/PA)
- ☐ Enclose a copy of Malpractice Liability Certificate *(copy of policy declarations page)*

☐ **Joining an Existing Group**
Upon approval, we will add you to existing network agreements applicable to your organization. Reimbursement during credentialing will apply from the date of your application.
- ☐ Complete the Louisiana Standardized Credentialing Application *(if not currently credentialed)*
  - ☐ Attachment A - Location Hours
- ☐ Enclose a copy of state license
- ☐ Enclose a copy of DEA/CDS Licenses *(where applicable)*
- ☐ Enclose a copy of Malpractice Liability Certificate *(copy of policy declarations page)*
- ☐ Enclose a copy of the Collaborating Physician Agreement/Supervising Physician Agreement (NP/PA). Collaborating physician must participate in the same network as the applicant.

☐ I wish to obtain a Blue Cross record only as a NON-PARTICIPATING provider
- ☐ Complete the Louisiana Standardized Credentialing Application
- ☐ Complete the iLinkBlue Service Agreement
- ☐ Complete the Business Associate Addendum to the iLinkBlue Service Agreement
- ☐ Complete the Electronic Funds Transfer (EFT) Enrollment Form
- ☐ Complete the Administrative Representative Registration Form
- ☐ Complete the Administrative Representative Acknowledgment Form
- ☐ Enclose an EIN Letter
- ☐ Enclose a W-9 Form
- ☐ Enclose a copy of state license

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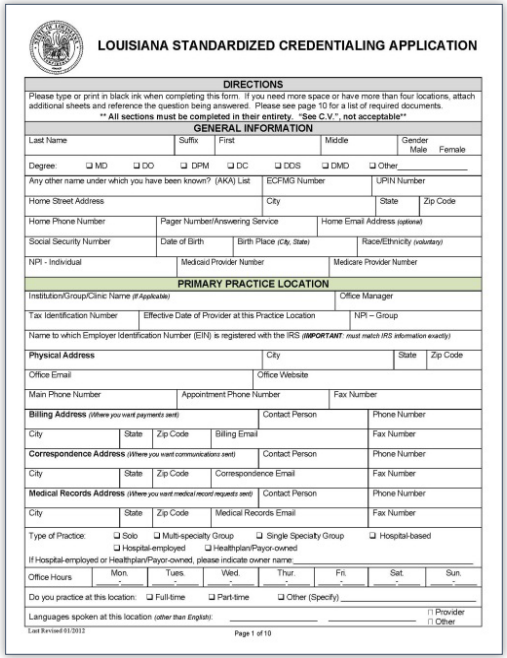
Blue Cross and Blue Shield of Louisiana is an independent licensee of the Blue Cross Blue Shield Association.

- The Professional (initial) credentialing packet includes a checklist of all required documents.
- To **join our networks through a new contract**, or **joining an existing group**, complete the checklist under "I wish to PARTICIPATE in Blue Cross' network(s)."
- If you **want a provider record only for filing claims**, complete the checklist under "I wish to obtain a Blue Cross record only as a NON-PARTICIPATING provider."

- **You must complete the applicable checklist and submit all the indicated documents.**
- **Credentialing packets with incomplete, missing information or submitted incorrectly will be returned.**

Initial Credentialing Application for Professional Providers

Blue Cross uses the Louisiana Standardized Credentialing Application (LSCA) for initial credentialing.



LOUISIANA STANDARDIZED CREDENTIALING APPLICATION

DIRECTIONS

Please type or print in black ink when completing this form. If you need more space or have more than four locations, attach additional sheets and reference the question being answered. Please see page 10 for a list of required documents.
**** All sections must be completed in their entirety. "See C.V.", not acceptable****

GENERAL INFORMATION

Last Name | Suffix | First | Middle | Gender Male Female

Degree: ❑ MD ❑ DO ❑ DPM ❑ DC ❑ DDS ❑ DMD ❑ Other_____

Any other name under which you have been known? (AKA) List | ECFMG Number | UPIN Number

Home Street Address | City | State | Zip Code

Home Phone Number | Pager Number/Answering Service | Home Email Address *(optional)*

Social Security Number | Date of Birth | Birth Place *(City, State)* | Race/Ethnicity *(voluntary)*

NPI - Individual | Medicaid Provider Number | Medicare Provider Number

PRIMARY PRACTICE LOCATION

Institution/Group/Clinic Name *(If Applicable)* | Office Manager

Tax Identification Number | Effective Date of Provider at this Practice Location | NPI – Group

Name to which Employer Identification Number (EIN) is registered with the IRS *(**IMPORTANT**: must match IRS information exactly)*

Physical Address | City | State | Zip Code

Office Email | Office Website

Main Phone Number | Appointment Phone Number | Fax Number

Billing Address *(Where you want payments sent)* | Contact Person | Phone Number

City | State | Zip Code | Billing Email | Fax Number

Correspondence Address *(Where you want communications sent)* | Contact Person | Phone Number

City | State | Zip Code | Correspondence Email | Fax Number

Medical Records Address *(Where you want medical record requests sent)* | Contact Person | Phone Number

City | State | Zip Code | Medical Records Email | Fax Number

Type of Practice: ❑ Solo ❑ Multi-specialty Group ❑ Single Specialty Group ❑ Hospital-based
❑ Hospital-employed ❑ Healthplan/Payor-owned
If Hospital-employed or Healthplan/Payor-owned, please indicate owner name: _____

Office Hours | Mon. | Tues. | Wed. | Thur. | Fri. | Sat. | Sun.

Do you practice at this location: ❑ Full-time ❑ Part-time ❑ Other (Specify) _____

Languages spoken at this location *(other than English)*: _____ _____ ☐ Provider ☐ Other

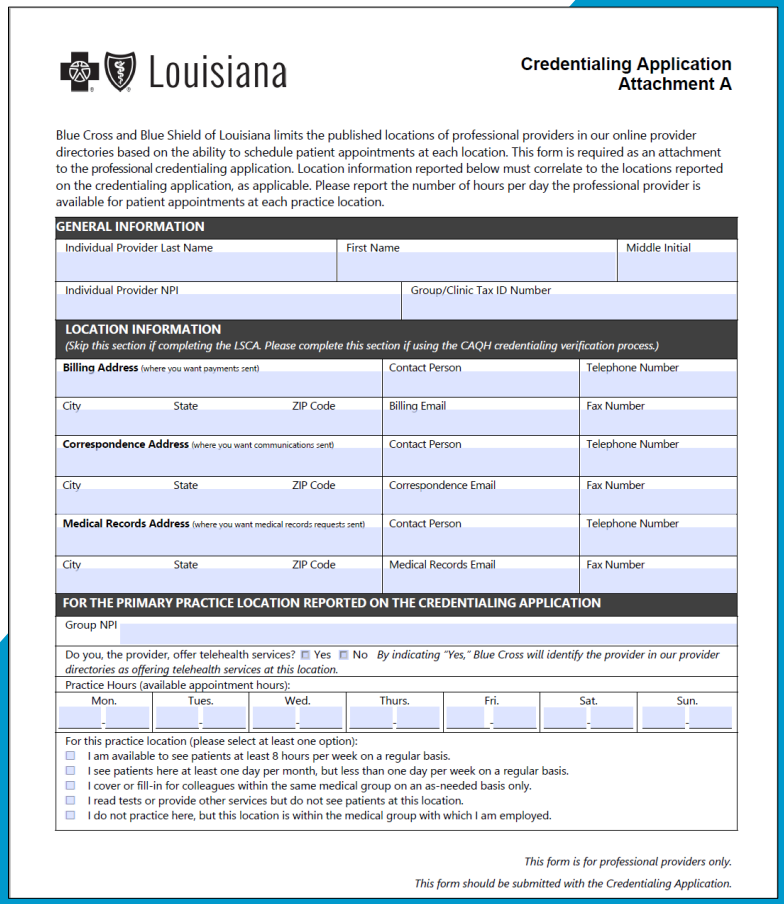
Last Revised 01/2012

Page 1 of 10

Find our credentialing links at **www.bcbsla.com/providers** >Provider Networks >Join Our Networks.

LSCA Attachment A – Location Hours

- This new form is **required** as an attachment to the LSCA.
- Use this form to report the number of hours per day the professional provider is available for patient appointments at each practice location.
- Location information reported on this form must correlate to the locations reported on the LSCA, as applicable.
- We use the information from this form to determine if the provider meets the qualifications to be listed in our provider directory.
- This form is also used report telehealth services.



Louisiana

Credentialing Application Attachment A

Blue Cross and Blue Shield of Louisiana limits the published locations of professional providers in our online provider directories based on the ability to schedule patient appointments at each location. This form is required as an attachment to the professional credentialing application. Location information reported below must correlate to the locations reported on the credentialing application, as applicable. Please report the number of hours per day the professional provider is available for patient appointments at each practice location.

GENERAL INFORMATION

Individual Provider Last Name	First Name	Middle Initial

Individual Provider NPI	Group/Clinic Tax ID Number

LOCATION INFORMATION

(Skip this section if completing the LSCA. Please complete this section if using the CAQH credentialing verification process.)

Billing Address (where you want payments sent)			Contact Person	Telephone Number
City	State	ZIP Code	Billing Email	Fax Number
Correspondence Address (where you want communications sent)			Contact Person	Telephone Number
City	State	ZIP Code	Correspondence Email	Fax Number
Medical Records Address (where you want medical records requests sent)			Contact Person	Telephone Number
City	State	ZIP Code	Medical Records Email	Fax Number

FOR THE PRIMARY PRACTICE LOCATION REPORTED ON THE CREDENTIALING APPLICATION

Group NPI

Do you, the provider, offer telehealth services? ☐ Yes ☐ No *By indicating "Yes," Blue Cross will identify the provider in our provider directories as offering telehealth services at this location.*

Practice Hours (available appointment hours):

Mon.	Tues.	Wed.	Thurs.	Fri.	Sat.	Sun.

For this practice location (please select at least one option):

- ☐ I am available to see patients at least 8 hours per week on a regular basis.
- ☐ I see patients here at least one day per month, but less than one day per week on a regular basis.
- ☐ I cover or fill-in for colleagues within the same medical group on an as-needed basis only.
- ☐ I read tests or provide other services but do not see patients at this location.
- ☐ I do not practice here, but this location is within the medical group with which I am employed.

This form is for professional providers only.

This form should be submitted with the Credentialing Application.

In order to be listed in the directory, professional providers must be available to schedule patients' appointments a minimum of 8 hours per week at the location listed.

Initial Credentialing for Facilities

Credentialing Criteria for Facility Providers

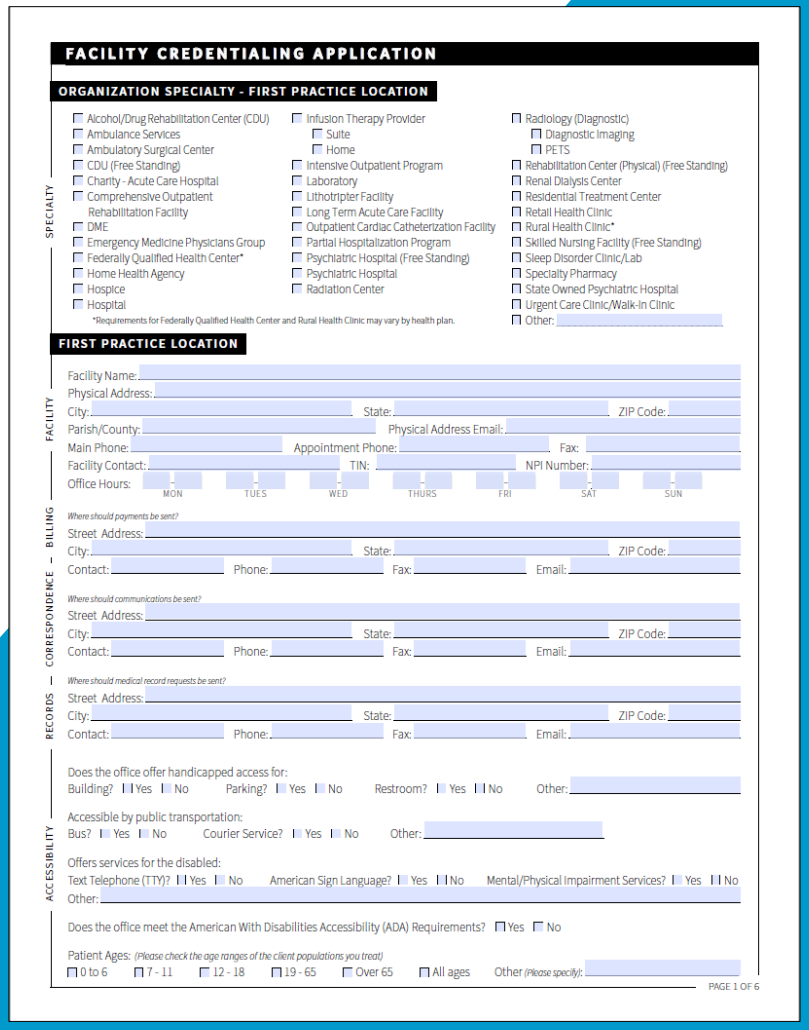
The following facility provider types must meet certain criteria requirements to participate in our networks:

- Ambulance Service
- Ambulatory Surgical Center
- Birthing Centers
- Cardiac Cath Lab (Outpatient)
- Diagnostic Services
- Dialysis Facility
- DME Supplier
- Emergency Medicine Physician Groups
- Home Health Agency
- Home Infusion
- Hospice
- Hospitals
- IOP/PHP Psych/CDU
- Laboratory
- Lithotripsy/Orthotripsy
- Nursing Home
- Radiation Center
- Residential Treatment
- Retail Health Clinic
- Skilled Nursing Facility
- Sleep Lab/Center
- Specialty Pharmacy
- Urgent Care Clinic

View the *Credentialing Criteria* for these facility provider types at **www.bcbsla.com/providers** >Network Enrollment >Join Our Networks >Facilities and Hospitals >Credentialing Process.

New Initial Facility Application

Blue Cross will begin using a new Facility Credentialing Application.



FACILITY CREDENTIALING APPLICATION

ORGANIZATION SPECIALTY - FIRST PRACTICE LOCATION

SPECIALTY

- Alcohol/Drug Rehabilitation Center (CDU)
- Ambulance Services
- Ambulatory Surgical Center
- CDU (Free Standing)
- Charity - Acute Care Hospital
- Comprehensive Outpatient Rehabilitation Facility
- DME
- Emergency Medicine Physicians Group
- Federally Qualified Health Center*
- Home Health Agency
- Hospice
- Hospital
- Infusion Therapy Provider
  - Suite
  - Home
- Intensive Outpatient Program
- Laboratory
- Lithotripter Facility
- Long Term Acute Care Facility
- Outpatient Cardiac Catheterization Facility
- Partial Hospitalization Program
- Psychiatric Hospital (Free Standing)
- Psychiatric Hospital
- Radiation Center
- Radiology (Diagnostic)
  - Diagnostic Imaging
  - PETS
- Rehabilitation Center (Physical) (Free Standing)
- Renal Dialysis Center
- Residential Treatment Center
- Retail Health Clinic
- Rural Health Clinic*
- Skilled Nursing Facility (Free Standing)
- Sleep Disorder Clinic/Lab
- Specialty Pharmacy
- State Owned Psychiatric Hospital
- Urgent Care Clinic/Walk-In Clinic
- Other:

*Requirements for Federally Qualified Health Center and Rural Health Clinic may vary by health plan.

FIRST PRACTICE LOCATION

FACILITY

Facility Name:
Physical Address:
City: State: ZIP Code:
Parish/County: Physical Address Email:
Main Phone: Appointment Phone: Fax:
Facility Contact: TIN: NPI Number:
Office Hours: MON TUES WED THURS FRI SAT SUN

BILLING

Where should payments be sent?
Street Address:
City: State: ZIP Code:
Contact: Phone: Fax: Email:

CORRESPONDENCE

Where should communications be sent?
Street Address:
City: State: ZIP Code:
Contact: Phone: Fax: Email:

RECORDS

Where should medical record requests be sent?
Street Address:
City: State: ZIP Code:
Contact: Phone: Fax: Email:

ACCESSIBILITY

Does the office offer handicapped access for:
Building? Yes No Parking? Yes No Restroom? Yes No Other:

Accessible by public transportation:
Bus? Yes No Courier Service? Yes No Other:

Offers services for the disabled:
Text Telephone (TTY)? Yes No American Sign Language? Yes No Mental/Physical Impairment Services? Yes No
Other:

Does the office meet the American With Disabilities Accessibility (ADA) Requirements? Yes No

Patient Ages: *(Please check the age ranges of the client populations you treat)*
0 to 6 7 - 11 12 - 18 19 - 65 Over 65 All ages Other *(Please specify)*:

PAGE 1 OF 6

Required Credentialing Forms for Facilities

As Applicable

The **HDO Information Form** may also require an HDO (Health Delivery Organization) attachment as indicated by facility type:

- HDO Attachment A: Ambulance Company
- HDO Attachment B: DME Supplier or Pharmacy
- HDO Attachment C: Hospital, Ambulatory Surgical Center or Free-standing Skilled Nursing Facilities
- HDO Attachment D: Urgent Care Clinic/Walk-In Clinic
- HDO Attachment E: Diagnostic Radiology (Free-standing)
- HDO Attachment F: Retail Health Clinics
- HDO Attachment G: Laboratory
- HDO Attachment H: Outpatient Cath Lab

Blue Cross still accepts the HDO Information Form and affiliated attachments.

Required Credentialing Forms for Facilities

As Applicable

Select facility types must also complete a **Facility Information Form(s)** as indicated by facility type:

- Facility Information Form A: Ambulance Company
- Facility Information Form B: DME Supplier or Pharmacy
- Facility Information Form C: Ambulatory Surgical Center, Hospital, IOP/PHP Psych/CDU, Skilled Nursing Facility, Long Term Acute Care, Rehabilitation Center
- Facility Information Form D: Urgent Care Clinic/ Walk-in Clinic
- Facility Information Form E: Diagnostic Radiology (Free Standing)
- Facility Information Form F: Retail Health Clinics
- Facility Information Form G: Laboratory
- Facility Information Form H: Outpatient Cath Lab

Blue Cross also accepts the Facility Information Form and affiliated attachments.

Required Supporting Documentation for Facilities

Blue Cross still accepts the HDO application checklist.

FACILITY CREDENTIALING APPLICATION CHECKLIST

All required documents must be fully completed (as applicable). Requests that are incomplete or missing information will be returned and the processing time will start over once all required information is received. Please return the completed checklist and required documents with the Facility Credentialing Application.

- ☐ Include a Facility Credentialing Application.
- ☐ Include applicable Facility Information Form Attachments *(required as part of the facility credentialing/recredentialing process for Blue Cross and Blue Shield of Louisiana)*:
  - ☐ Facility Information Form Attachment A: Ambulance Company
  - ☐ Facility Information Form Attachment B: DME Supplier
  - ☐ Facility Information Form Attachment C: Ambulatory Surgical Center, Hospital, IOP/PHP Psych/CDU, Skilled Nursing Facility, Long Term Acute Care, Rehabilitation Center
  - ☐ Facility Information Form Attachment D: Urgent Care/Walk-in Clinic
  - ☐ Facility Information Form Attachment E: Diagnostic Services
  - ☐ Facility Information Form Attachment F: Retail Health Clinic
  - ☐ Facility Information Form Attachment G: Laboratory
  - ☐ Facility Information Form Attachment H: Outpatient Cath Lab
- ☐ If accredited, include a copy of the current Accreditation Certificate.
- ☐ Include a copy of current state license.
- ☐ Include a W-9 Form.
- ☐ Include an EIN Letter.
- ☐ Include a copy of Malpractice Liability Certificate. DME providers only need to submit Products Liability Insurance Coverage Information.
- ☐ Include a copy of the DEQ license for Radiation Center.
- ☐ Include a copy of the Act 354 Form for Ambulatory Surgical Center and Hospital *(required as part of the facility credentialing/recredentialing process for Vantage Health Plan).*
- ☐ If facility has 50+ beds, include a copy of the Patient Safety Regulation Attestation for General Acute Hospital, Skilled Nursing Facility, Long Term Acute Care or Physical Rehabilitation Center.
- ☐ Include a copy of the Surety Bond for DME Suppliers *(required as part of the facility credentialing/recredentialing process for Vantage Health Plan).*
- ☐ Include a copy of the Federal Qualified RHC Letter for Rural Health Clinic *(required as part of the facility credentialing/recredentialing process for Vantage Health Plan).*

SUBMIT ALL REQUIRED DOCUMENTS USING ONE OF THE OPTIONS BELOW

Mail:

Vantage Health Plan – Credentialing Dept.
130 DeSiard Street, Suite 300
Monroe, LA 71201

Email:

recredentialing@vhpla.com

VHP4019_123021_APPROVED

- **You must complete the applicable checklist and submit all indicated documents.**
- **Credentialing packets with incomplete, missing information or submitted incorrectly will be returned.**

Recredentialing Process

(for both Professional Providers & Facilities)

Blue Cross Recredentialing Process

Use the chart below for the recredentialing process:

Process initiated by:	Vantage:
Form(s) to complete for professional provider recredentialing:	CAQH Application or Louisiana Standardized Credentialing Application (LSCA).
Form(s) to complete for facility reverification:	Facility Credentialing Application, Facility Credentialing Application Checklist and any applicable Facility Information Form Attachments.
Where to submit forms:	To Vantage based on instructions included with recredentialing form.
Verification Process:	Vantage
Who to contact:	Vantage by email: **recredentialing@vhpla.com** Vantage by phone: (318) 807-4755

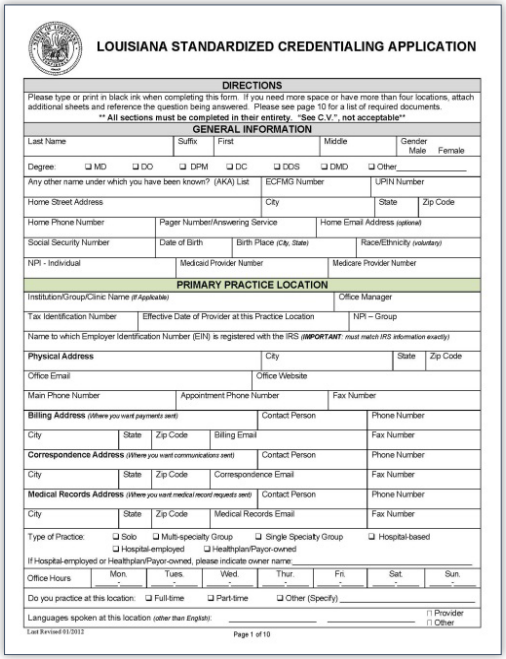
Credentialing Update

We partner with **symplrCVO**, to assist with the primary source verification of our credentialing and recredentialing applications.

Providers in the credentialing and recredentialing process may be directly contacted by symplrCVO to verify application details and supporting documentation.

If you have additional questions, you may email our Provider Relations Department at **provider.relations@bcbsla.com**. We appreciate your understanding as we work to expedite application processing.

Professional Providers Recredentialing Applications



LOUISIANA STANDARDIZED CREDENTIALING APPLICATION

DIRECTIONS

Please type or print in black ink when completing this form. If you need more space or have more than four locations, attach additional sheets and reference the question being answered. Please see page 10 for a list of required documents.
** All sections must be completed in their entirety. "See C.V.", not acceptable**

GENERAL INFORMATION

Last Name | Suffix | First | Middle | Gender Male Female

Degree: ❑ MD ❑ DO ❑ DPM ❑ DC ❑ DDS ❑ DMD ❑ Other

Any other name under which you have been known? (AKA) List | ECFMG Number | UPIN Number

Home Street Address | City | State | Zip Code

Home Phone Number | Pager Number/Answering Service | Home Email Address (optional)

Social Security Number | Date of Birth | Birth Place (City, State) | Race/Ethnicity (voluntary)

NPI - Individual | Medicaid Provider Number | Medicare Provider Number

PRIMARY PRACTICE LOCATION

Institution/Group/Clinic Name (If Applicable) | Office Manager

Tax Identification Number | Effective Date of Provider at this Practice Location | NPI – Group

Name to which Employer Identification Number (EIN) is registered with the IRS (IMPORTANT: must match IRS information exactly)

Physical Address | City | State | Zip Code

Office Email | Office Website

Main Phone Number | Appointment Phone Number | Fax Number

Billing Address (Where you want payments sent) | Contact Person | Phone Number

City | State | Zip Code | Billing Email | Fax Number

Correspondence Address (Where you want communications sent) | Contact Person | Phone Number

City | State | Zip Code | Correspondence Email | Fax Number

Medical Records Address (Where you want medical record requests sent) | Contact Person | Phone Number

City | State | Zip Code | Medical Records Email | Fax Number

Type of Practice: ❑ Solo ❑ Multi-specialty Group ❑ Single Specialty Group ❑ Hospital-based
❑ Hospital-employed ❑ Healthplan/Payor-owned
If Hospital-employed or Healthplan/Payor-owned, please indicate owner name:

Office Hours | Mon. | Tues. | Wed. | Thur. | Fri. | Sat. | Sun.

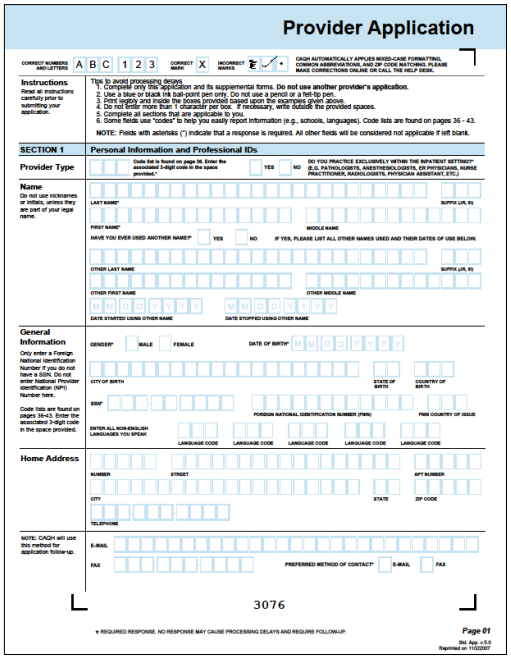
Do you practice at this location: ❑ Full-time ❑ Part-time ❑ Other (Specify)

Languages spoken at this location (other than English): ☐ Provider ☐ Other

Last Revised 01/2012

Page 1 of 10

Vantage accepts the LSCA, as well as the CAHQ application.



Provider Application

CORRECT NUMBERS AND LETTERS: A B C 1 2 3 | CORRECT MARK: X | INCORRECT MARKS | CAQH AUTOMATICALLY APPLIES MIXED-CASE FORMATTING, COMMON ABBREVIATIONS, AND ZIP CODE MATCHING. PLEASE MAKE CORRECTIONS ONLINE OR CALL THE HELP DESK.

Instructions
Read all instructions carefully prior to submitting your application.

Tips to avoid processing delays
1. Complete only this application and its supplemental forms. Do not use another provider's application.
2. Use a blue or black ink ball-point pen only. Do not use a pencil or a felt-tip pen.
3. Print legibly and inside the boxes provided based upon the examples given above.
4. Do not limit more than 1 character per box. If necessary, write outside the provided spaces.
5. Complete all sections that are applicable to you.
6. Some fields use "codes" to help you easily report information (e.g., schools, languages). Code lists are found on pages 36 - 43.

NOTE: Fields with asterisks (*) indicate that a response is required. All other fields will be considered not applicable if left blank.

SECTION 1 — **Personal Information and Professional IDs**

Provider Type — Code list is found on page 36. Enter the associated 2-digit code in the space provided.* | YES | NO | DO YOU PRACTICE EXCLUSIVELY WITHIN THE INPATIENT SETTING?* (E.G. PATHOLOGISTS, ANESTHESIOLOGISTS, ER PHYSICIANS, NURSE PRACTITIONER, RADIOLOGISTS, PHYSICIAN ASSISTANT, ETC.)

Name
Do not use nicknames or initials, unless they are part of your legal name.

LAST NAME* | SUFFIX (JR, III)
FIRST NAME* | MIDDLE NAME
HAVE YOU EVER USED ANOTHER NAME?* YES NO IF YES, PLEASE LIST ALL OTHER NAMES USED AND THEIR DATES OF USE BELOW.
OTHER LAST NAME | SUFFIX (JR, III)
OTHER FIRST NAME | OTHER MIDDLE NAME
M M D D Y Y Y Y | DATE STARTED USING OTHER NAME
M M D D Y Y Y Y | DATE STOPPED USING OTHER NAME

General Information
Only enter a Foreign National Identification Number if you do not have a SSN. Do not enter National Provider Identification (NPI) Number here.

Code lists are found on pages 36-43. Enter the associated 3-digit code in the space provided.

GENDER* MALE FEMALE | DATE OF BIRTH* M M D D Y Y Y Y
CITY OF BIRTH | STATE OF BIRTH | COUNTRY OF BIRTH
SSN* | FOREIGN NATIONAL IDENTIFICATION NUMBER (FNN) | FNN COUNTRY OF ISSUE
ENTER ALL NON-ENGLISH LANGUAGES YOU SPEAK | LANGUAGE CODE | LANGUAGE CODE | LANGUAGE CODE | LANGUAGE CODE | LANGUAGE CODE

Home Address
NUMBER | STREET | APT NUMBER
CITY | STATE | ZIP CODE
TELEPHONE

NOTE: CAQH will use this method for application follow-up.
E-MAIL
FAX | PREFERRED METHOD OF CONTACT* E-MAIL FAX

3076

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Page 01

Std. App. v.5.0
Reprinted on 11/2/2007

Find our credentialing links at **www.bcbsla.com/providers** >Network Enrollment >Join Our Networks.

Required Recredentialing Supporting Documentation for Professional Providers

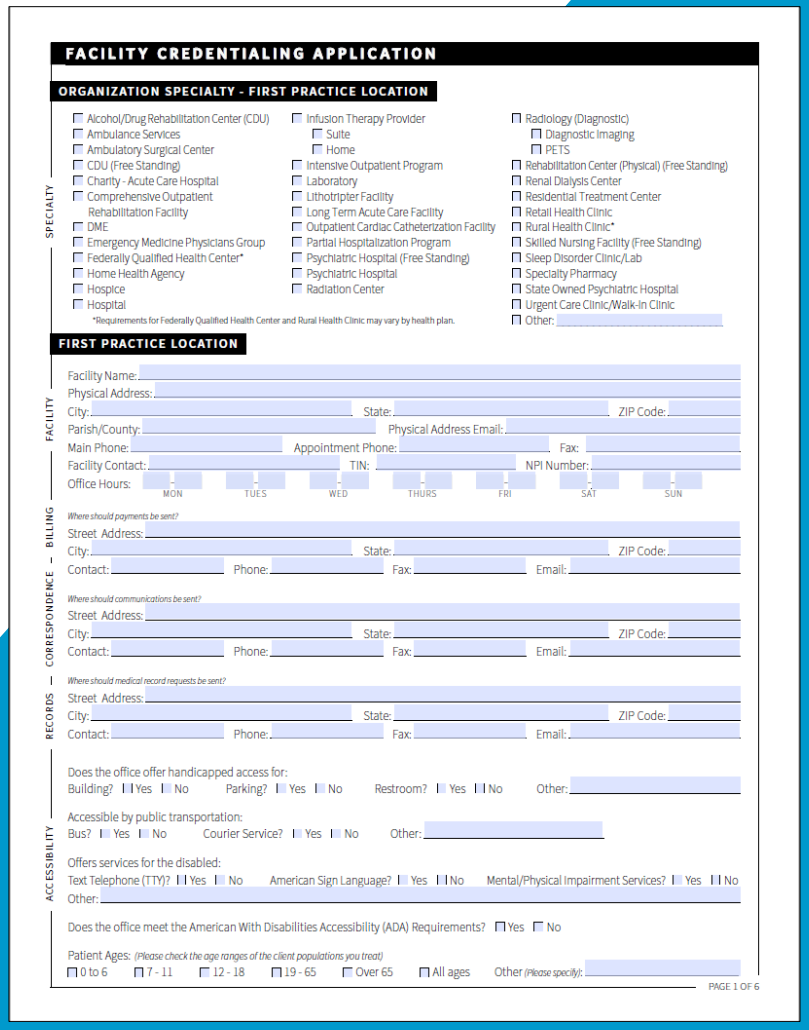
The following documents must be submitted with your recredentialing application:

- Copy of state license.
- Copy of DEA registration and CDS license *(as applicable)*.
- Copy of Malpractice Liability Certificate (*copy of policy declarations page*).
- Complete the LSCA Attachment A - Location Hours.
- **Enclose a copy of the Collaborative Physician Agreement/Supervising Physician Agreement for NPs and PAs.**

- **You must complete the applicable checklist and submit all the indicated documents.**
- **Recredentialing packets with incomplete, missing information or submitted incorrectly will be returned.**

Facility Credentialing Application

We use the Facility Credentialing Application to recredential facilities.



FACILITY CREDENTIALING APPLICATION

ORGANIZATION SPECIALTY - FIRST PRACTICE LOCATION

SPECIALTY

- Alcohol/Drug Rehabilitation Center (CDU)
- Ambulance Services
- Ambulatory Surgical Center
- CDU (Free Standing)
- Charity - Acute Care Hospital
- Comprehensive Outpatient Rehabilitation Facility
- DME
- Emergency Medicine Physicians Group
- Federally Qualified Health Center*
- Home Health Agency
- Hospice
- Hospital
- Infusion Therapy Provider
  - Suite
  - Home
- Intensive Outpatient Program
- Laboratory
- Lithotripter Facility
- Long Term Acute Care Facility
- Outpatient Cardiac Catheterization Facility
- Partial Hospitalization Program
- Psychiatric Hospital (Free Standing)
- Psychiatric Hospital
- Radiation Center
- Radiology (Diagnostic)
  - Diagnostic Imaging
  - PETS
- Rehabilitation Center (Physical) (Free Standing)
- Renal Dialysis Center
- Residential Treatment Center
- Retail Health Clinic
- Rural Health Clinic*
- Skilled Nursing Facility (Free Standing)
- Sleep Disorder Clinic/Lab
- Specialty Pharmacy
- State Owned Psychiatric Hospital
- Urgent Care Clinic/Walk-In Clinic
- Other:

*Requirements for Federally Qualified Health Center and Rural Health Clinic may vary by health plan.

FIRST PRACTICE LOCATION

FACILITY

Facility Name:
Physical Address:
City: State: ZIP Code:
Parish/County: Physical Address Email:
Main Phone: Appointment Phone: Fax:
Facility Contact: TIN: NPI Number:
Office Hours: MON TUES WED THURS FRI SAT SUN

BILLING

Where should payments be sent?
Street Address:
City: State: ZIP Code:
Contact: Phone: Fax: Email:

CORRESPONDENCE

Where should communications be sent?
Street Address:
City: State: ZIP Code:
Contact: Phone: Fax: Email:

RECORDS

Where should medical record requests be sent?
Street Address:
City: State: ZIP Code:
Contact: Phone: Fax: Email:

ACCESSIBILITY

Does the office offer handicapped access for:
Building? Yes No Parking? Yes No Restroom? Yes No Other:

Accessible by public transportation:
Bus? Yes No Courier Service? Yes No Other:

Offers services for the disabled:
Text Telephone (TTY)? Yes No American Sign Language? Yes No Mental/Physical Impairment Services? Yes No
Other:

Does the office meet the American With Disabilities Accessibility (ADA) Requirements? Yes No

Patient Ages: *(Please check the age ranges of the client populations you treat)*
0 to 6 7 - 11 12 - 18 19 - 65 Over 65 All ages Other *(Please specify)*:

PAGE 1 OF 6

Other Required Forms

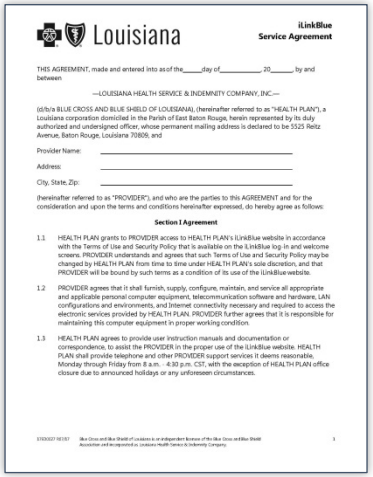
(for both Professional Providers & Facilities)

iLinkBlue Application Packet

iLinkBlue is our secure online tool for professional and facility healthcare providers. It is designed to help you quickly complete important functions such as eligibility and coverage verification, claims filing and review, payment queries and transactions.

The **iLinkBlue Application Packet** is included in our credentialing packets. These documents are required to access iLinkBlue and become a participating provider.

Below are the four parts:


Louisiana

iLinkBlue Service Agreement

THIS AGREEMENT, made and entered into as of the_____day of_____, 20_____, by and between

—LOUISIANA HEALTH SERVICE & INDEMNITY COMPANY, INC.—

(d/b/a BLUE CROSS AND BLUE SHIELD OF LOUISIANA), (hereinafter referred to as "HEALTH PLAN"), a Louisiana corporation domiciled in the Parish of East Baton Rouge, herein represented by its duly authorized and undersigned officer, whose permanent mailing address is declared to be 5525 Reitz Avenue, Baton Rouge, Louisiana 70809, and

Provider Name: _____

Address: _____

City, State, Zip: _____

(hereinafter referred to as "PROVIDER"), and who are the parties to this AGREEMENT and for the consideration and upon the terms and conditions hereinafter expressed, do hereby agree as follows:

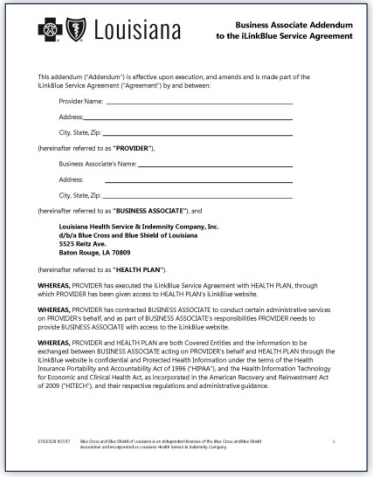
Section I Agreement

1.1 HEALTH PLAN grants to PROVIDER access to HEALTH PLAN's iLinkBlue website in accordance with the Terms of Use and Security Policy that is available on the iLinkBlue log-in and welcome screens. PROVIDER understands and agrees that such Terms of Use and Security Policy may be changed by HEALTH PLAN from time to time under HEALTH PLAN's sole discretion, and that PROVIDER will be bound by such terms as a condition of its use of the iLinkBlue website.

1.2 PROVIDER agrees that it shall furnish, supply, configure, maintain, and service all appropriate and applicable personal computer equipment, telecommunication software and hardware, LAN configurations and environments, and Internet connectivity necessary and required to access the electronic services provided by HEALTH PLAN. PROVIDER further agrees that it is responsible for maintaining this computer equipment in proper working condition.

1.3 HEALTH PLAN agrees to provide user instruction manuals and documentation or correspondence, to assist the PROVIDER in the proper use of the iLinkBlue website. HEALTH PLAN shall provide telephone and other PROVIDER support services it deems reasonable, Monday through Friday from 8 a.m. - 4:30 p.m. CST, with the exception of HEALTH PLAN office closure due to announced holidays or any unforeseen circumstances.

iLinkBlue Service Agreement


Louisiana

Business Associate Addendum to the iLinkBlue Service Agreement

This addendum ("Addendum") is effective upon execution, and amends and is made part of the iLinkBlue Service Agreement ("Agreement") by and between:

Provider Name: _____

Address: _____

City, State, Zip: _____

(hereinafter referred to as "**PROVIDER**"),

Business Associate's Name: _____

Address: _____

City, State, Zip: _____

(hereinafter referred to as "**BUSINESS ASSOCIATE**"), and

Louisiana Health Service & Indemnity Company, Inc.
d/b/a Blue Cross and Blue Shield of Louisiana
5525 Reitz Ave.
Baton Rouge, LA 70809

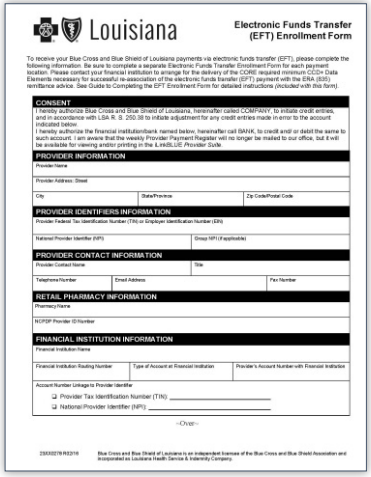
(hereinafter referred to as "**HEALTH PLAN**").

WHEREAS, PROVIDER has executed the iLinkBlue Service Agreement with HEALTH PLAN, through which PROVIDER has been given access to HEALTH PLAN's iLinkBlue website.

WHEREAS, PROVIDER has contracted BUSINESS ASSOCIATE to conduct certain administrative services on PROVIDER's behalf, and as part of BUSINESS ASSOCIATE's responsibilities PROVIDER needs to provide BUSINESS ASSOCIATE with access to the iLinkBlue website.

WHEREAS, PROVIDER and HEALTH PLAN are both Covered Entities and the information to be exchanged between BUSINESS ASSOCIATE acting on PROVIDER's behalf and HEALTH PLAN through the iLinkBlue website is confidential and Protected Health Information under the terms of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), and the Health Information Technology for Economic and Clinical Health Act, as incorporated in the American Recovery and Reinvestment Act of 2009 ("HITECH"), and their respective regulations and administrative guidance.

Business Associate Addendum


Louisiana

Electronic Funds Transfer (EFT) Enrollment Form

To receive your Blue Cross and Blue Shield of Louisiana payments via electronic funds transfer (EFT), please complete the following information. Be sure to complete a separate Electronic Funds Transfer Enrollment Form for each payment location. Please contact your financial institution to arrange for the delivery of the CORE required minimum CCD+ Data Elements necessary for successful re-association of the electronic funds transfer (EFT) payment with the ERA (835) remittance advice. See Guide to Completing the EFT Enrollment Form for detailed instructions (included with this form).

CONSENT

I hereby authorize Blue Cross and Blue Shield of Louisiana, hereinafter called COMPANY, to initiate credit entries, and in accordance with LSA R. S. 250.38 to initiate adjustment for any credit entries made in error to the account indicated below.
I hereby authorize the financial institution/bank named below, hereinafter call BANK, to credit and/or debit the same to such account. I am aware that the weekly Provider Payment Register will no longer be mailed to our office, but it will be available for viewing and/or printing in the *iLinkBLUE Provider Suite*.

PROVIDER INFORMATION

Provider Name
Provider Address: Street
City | State/Province | Zip Code/Postal Code

PROVIDER IDENTIFIERS INFORMATION

Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN)
National Provider Identifier (NPI) | Group NPI (if applicable)

PROVIDER CONTACT INFORMATION

Provider Contact Name | Title
Telephone Number | Email Address | Fax Number

RETAIL PHARMACY INFORMATION

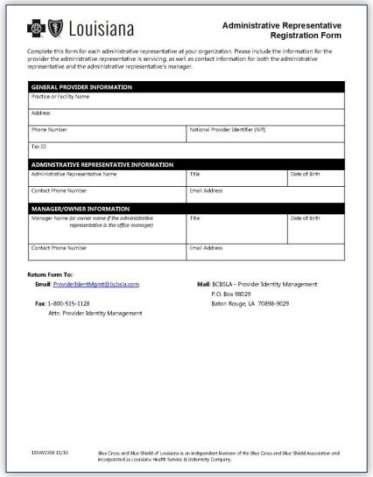
Pharmacy Name
NCPDP Provider ID Number

FINANCIAL INSTITUTION INFORMATION

Financial Institution Name
Financial Institution Routing Number | Type of Account at Financial Institution | Provider's Account Number with Financial Institution
Account Number Linkage to Provider Identifier
❑ Provider Tax Identification Number (TIN) _____
❑ National Provider Identifier (NPI) _____

<Over>

Electronic Funds Transfer (EFT) Enrollment Form


Louisiana

Administrative Representative Registration Form

Complete this form for each administrative representative at your organization. Please include the information for the provider the administrative representative is servicing, as well as contact information for both the administrative representative and the administrative representative's manager.

GENERAL PROVIDER INFORMATION

Practice or Facility Name
Address
Phone Number | National Provider Identifier (NPI)
Tax ID

ADMINISTRATIVE REPRESENTATIVE INFORMATION

Administrative Representative Name | Title | Date of Birth
Contact Phone Number | Email Address

MANAGER/OWNER INFORMATION

Manager Name (or owner name if the administrative representative is the office manager) | Title | Date of Birth
Contact Phone Number | Email Address

Return Form To:

Email: ProviderIdentityMgmt@bcbsla.com

Fax: 1-800-515-1128
Attn: Provider Identity Management

Mail: BCBSLA - Provider Identity Management
P.O. Box 98029
Baton Rouge, LA 70898-9029

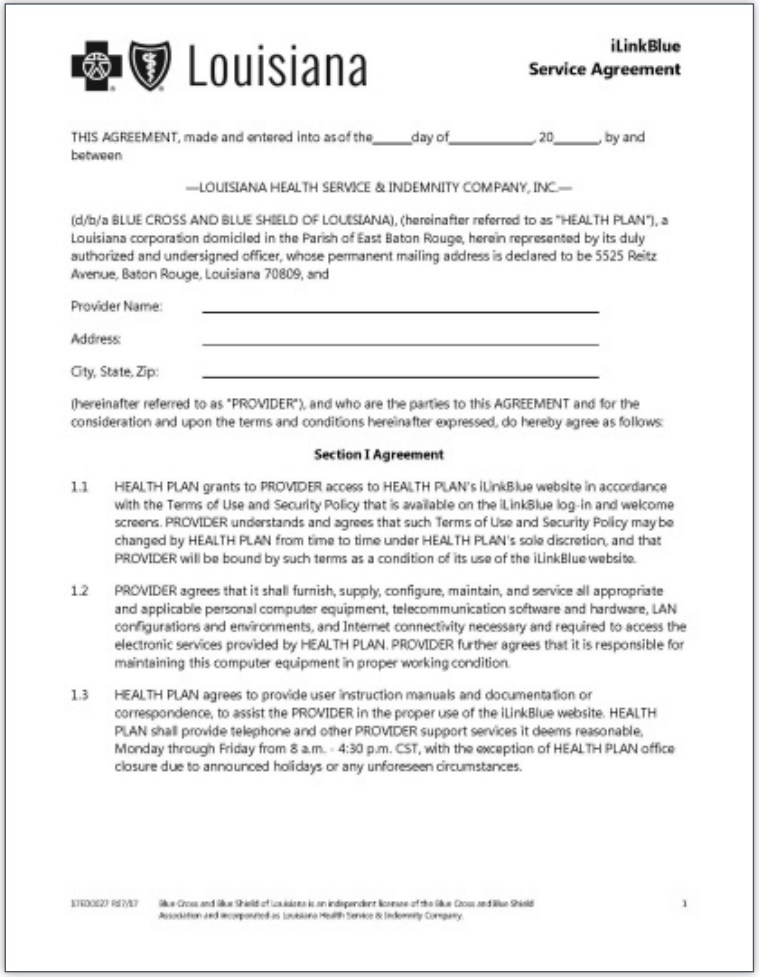
Administrative Representative Registration Form

The iLinkBlue Application Packet is also available online at **www.bcbsla.com/providers** >Electronic Services >iLinkBlue.

iLinkBlue Application Packet

Included in the iLinkBlue packet:

The **iLinkBlue Service Agreement** is a legal agreement between the provider and Blue Cross and Blue Shield of Louisiana required for accessing iLinkBlue.



Louisiana

iLinkBlue Service Agreement

THIS AGREEMENT, made and entered into as of the_____day of_____, 20_____, by and between

—LOUISIANA HEALTH SERVICE & INDEMNITY COMPANY, INC.—

(d/b/a BLUE CROSS AND BLUE SHIELD OF LOUISIANA), (hereinafter referred to as "HEALTH PLAN"), a Louisiana corporation domiciled in the Parish of East Baton Rouge, herein represented by its duly authorized and undersigned officer, whose permanent mailing address is declared to be 5525 Reitz Avenue, Baton Rouge, Louisiana 70809, and

Provider Name: _____

Address: _____

City, State, Zip: _____

(hereinafter referred to as "PROVIDER"), and who are the parties to this AGREEMENT and for the consideration and upon the terms and conditions hereinafter expressed, do hereby agree as follows:

Section I Agreement

1.1 HEALTH PLAN grants to PROVIDER access to HEALTH PLAN's iLinkBlue website in accordance with the Terms of Use and Security Policy that is available on the iLinkBlue log-in and welcome screens. PROVIDER understands and agrees that such Terms of Use and Security Policy may be changed by HEALTH PLAN from time to time under HEALTH PLAN's sole discretion, and that PROVIDER will be bound by such terms as a condition of its use of the iLinkBlue website.

1.2 PROVIDER agrees that it shall furnish, supply, configure, maintain, and service all appropriate and applicable personal computer equipment, telecommunication software and hardware, LAN configurations and environments, and Internet connectivity necessary and required to access the electronic services provided by HEALTH PLAN. PROVIDER further agrees that it is responsible for maintaining this computer equipment in proper working condition.

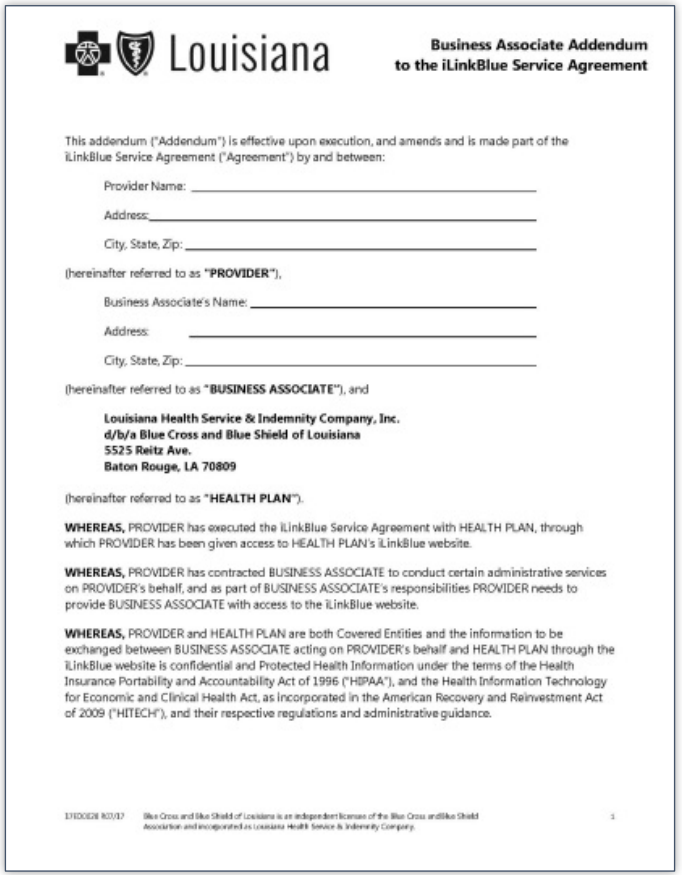
1.3 HEALTH PLAN agrees to provide user instruction manuals and documentation or correspondence, to assist the PROVIDER in the proper use of the iLinkBlue website. HEALTH PLAN shall provide telephone and other PROVIDER support services it deems reasonable, Monday through Friday from 8 a.m. - 4:30 p.m. CST, with the exception of HEALTH PLAN office closure due to announced holidays or any unforeseen circumstances.

iLinkBlue Application Packet

Included in the iLinkBlue packet:

- The **Business Associate Addendum** is used to grant third-party agents such as a billing agency or management company access to iLinkBlue under the provider's iLinkBlue Service Agreement.

- It is required only if the provider uses a billing agency or management company that will need to access iLinkBlue on behalf of the provider.



Louisiana

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Provider Name: _____

Address: _____

City, State, Zip: _____

(hereinafter referred to as "**PROVIDER**"),

Business Associate's Name: _____

Address: _____

City, State, Zip: _____

(hereinafter referred to as "**BUSINESS ASSOCIATE**"), and

Louisiana Health Service & Indemnity Company, Inc.
d/b/a Blue Cross and Blue Shield of Louisiana
5525 Reitz Ave.
Baton Rouge, LA 70809

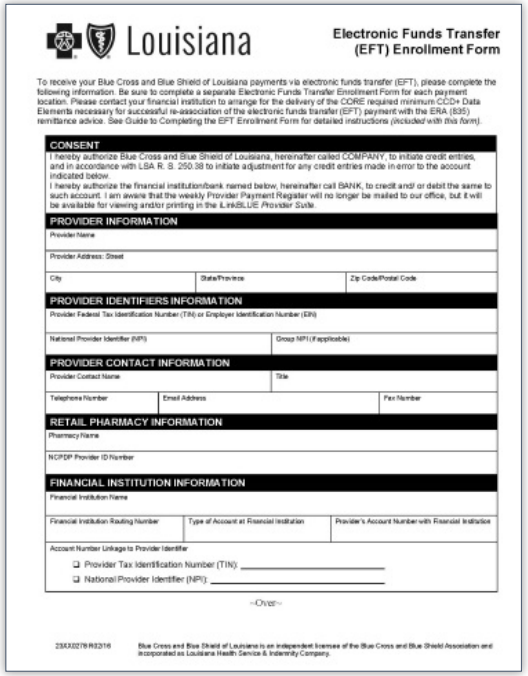
(hereinafter referred to as "**HEALTH PLAN**").

WHEREAS, PROVIDER has executed the iLinkBlue Service Agreement with HEALTH PLAN, through which PROVIDER has been given access to HEALTH PLAN's iLinkBlue website.

WHEREAS, PROVIDER has contracted BUSINESS ASSOCIATE to conduct certain administrative services on PROVIDER's behalf, and as part of BUSINESS ASSOCIATE's responsibilities PROVIDER needs to provide BUSINESS ASSOCIATE with access to the iLinkBlue website.

WHEREAS, PROVIDER and HEALTH PLAN are both Covered Entities and the information to be exchanged between BUSINESS ASSOCIATE acting on PROVIDER's behalf and HEALTH PLAN through the iLinkBlue website is confidential and Protected Health Information under the terms of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), and the Health Information Technology for Economic and Clinical Health Act, as incorporated in the American Recovery and Reinvestment Act of 2009 ("HITECH"), and their respective regulations and administrative guidance.

Electronic Funds Transfer (EFT) Enrollment Form



Louisiana

Electronic Funds Transfer (EFT) Enrollment Form

To receive your Blue Cross and Blue Shield of Louisiana payments via electronic funds transfer (EFT), please complete the following information. Be sure to complete a separate Electronic Funds Transfer Enrollment Form for each payment location. Please contact your financial institution to arrange for the delivery of the CORE required minimum CCD+ Data Elements necessary for successful re-association of the electronic funds transfer (EFT) payment with the ERA (835) remittance advice. See Guide to Completing the EFT Enrollment Form for detailed instructions *(included with this form)*.

CONSENT

I hereby authorize Blue Cross and Blue Shield of Louisiana, hereinafter called COMPANY, to initiate credit entries, and in accordance with LSA R. S. 250.38 to initiate adjustment for any credit entries made in error to the account indicated below.
I hereby authorize the financial institution/bank named below, hereinafter call BANK, to credit and/ or debit the same to such account. I am aware that the weekly Provider Payment Register will no longer be mailed to our office, but it will be available for viewing and/or printing in the *iLinkBLUE Provider Suite*.

PROVIDER INFORMATION

Provider Name

Provider Address: Street

City | State/Province | Zip Code/Postal Code

PROVIDER IDENTIFIERS INFORMATION

Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN)

National Provider Identifier (NPI) | Group NPI (If applicable)

PROVIDER CONTACT INFORMATION

Provider Contact Name | Title

Telephone Number | Email Address | Fax Number

RETAIL PHARMACY INFORMATION

Pharmacy Name

NCPDP Provider ID Number

FINANCIAL INSTITUTION INFORMATION

Financial Institution Name

Financial Institution Routing Number | Type of Account at Financial Institution | Provider's Account Number with Financial Institution

Account Number Linkage to Provider Identifier

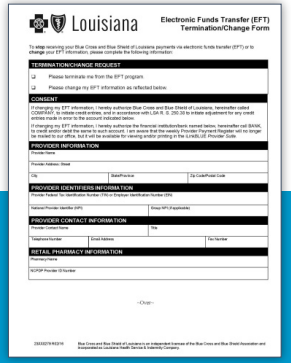
- ❑ Provider Tax Identification Number (TIN): _____
- ❑ National Provider Identifier (NPI): _____

~Over~

23XX0279 R03/16 Blue Cross and Blue Shield of Louisiana is an independent licensee of the Blue Cross and Blue Shield Association and incorporated as Louisiana Health Service & Indemnity Company.

- EFT is a free provider service where Blue Cross deposits your payment directly into your checking account.
- With iLinkBlue, you have access to EFT notifications and Payment Registers/Remittance Advices (can be printed directly).
- All Blue Cross providers **must** be part of our EFT program, including those signed up for iLinkBlue.
- The EFT Enrollment Form includes a guide with detailed instructions on how to complete the form.

These forms are also available online at
www.bcbsla.com/providers >Resources >Forms.



Louisiana

Electronic Funds Transfer (EFT) Termination/Change Form

TERMINATION/CHANGE REQUEST

❑ Please terminate me from the EFT program.

❑ Please change my EFT information as reflected below.

CONSENT

If changing my EFT information, I hereby authorize Blue Cross and Blue Shield of Louisiana, hereinafter called COMPANY, to initiate credit entries, and in accordance with LSA R. S. 250.38 to initiate adjustment for any credit entries made in error to the account indicated below.

If changing my EFT information, I hereby authorize the financial institution/bank named below, hereinafter call BANK, to credit and/or debit the same to such account. I am aware that the weekly Provider Payment Register will no longer be mailed to our office, but it will be available for viewing and/or printing in the *iLinkBLUE Provider Suite*.

PROVIDER INFORMATION

Provider Name

Provider Address: Street

City | State/Province | Zip Code/Postal Code

PROVIDER IDENTIFIERS INFORMATION

Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN)

National Provider Identifier (NPI) | Group NPI (If applicable)

PROVIDER CONTACT INFORMATION

Provider Contact Name | Title

Telephone Number | Email Address | Fax Number

RETAIL PHARMACY INFORMATION

Pharmacy Name

NCPDP Provider ID Number

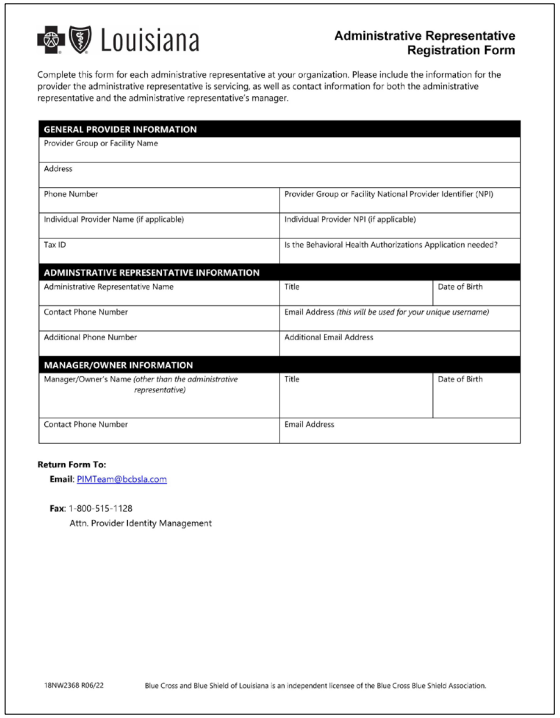
~Over~

23XX0279 R03/16 Blue Cross and Blue Shield of Louisiana is an independent licensee of the Blue Cross and Blue Shield Association and incorporated as Louisiana Health Service & Indemnity Company.

To change or update your Blue Cross payments via EFT, complete the Provider Update Request Form.

Administrative Representative Registration

- We require that each provider organization designate at least one administrative representative to self-manage user access to our secure online services.
- Your administrative representative is responsible for managing your secure access to the following Blue Cross online services:
  - iLinkBlue
  - BCBSLA authorizations
  - Behavioral health authorizations
  - Pre-service review for out-of-area members (BlueCard® members)
  - and more
- If you are part of a provider group or facility that already has registered an administrative representative with Blue Cross, you do not have to submit the Administrative Representative Registration Form.



Louisiana

Administrative Representative Registration Form

Complete this form for each administrative representative at your organization. Please include the information for the provider the administrative representative is servicing, as well as contact information for both the administrative representative and the administrative representative's manager.

GENERAL PROVIDER INFORMATION		
Provider Group or Facility Name		
Address		
Phone Number	Provider Group or Facility National Provider Identifier (NPI)	
Individual Provider Name (if applicable)	Individual Provider NPI (if applicable)	
Tax ID	Is the Behavioral Health Authorizations Application needed?	
ADMINSTRATIVE REPRESENTATIVE INFORMATION		
Administrative Representative Name	Title	Date of Birth
Contact Phone Number	Email Address *(this will be used for your unique username)*	
Additional Phone Number	Additional Email Address	
MANAGER/OWNER INFORMATION		
Manager/Owner's Name *(other than the administrative representative)*	Title	Date of Birth
Contact Phone Number	Email Address	

Return Form To:
Email: PIMTeam@bcbsla.com

Fax: 1-800-515-1128
Attn. Provider Identity Management

18NW2368 R06/22 Blue Cross and Blue Shield of Louisiana is an independent licensee of the Blue Cross Blue Shield Association.

The Administrative Representative Registration packet is also available online at **www.bcbsla.com/providers** >Electronic Services >Admin Reps.

Provider Directory

Keeping your information up to date with us is extremely important to help our members find you.

We publish demographic information in our online provider directory. The directory is available on our website at **www.bcbsla.com**.

It is the contractual responsibility of all participating providers to contact Provider Credentialing & Data Management to update your information as soon as it changes. This includes:

- Addresses (location information)
- Phone numbers
- Accepting new patients
- Providers working at certain locations
  - In order to be listed in the directory, professional providers must be available to schedule patients' appointments a minimum of 8 hours per week at the location listed.
  - Provide information about telehealth services.

To improve the accuracy of our online provider directory, we are making changes to help create the most accurate directory for our members.

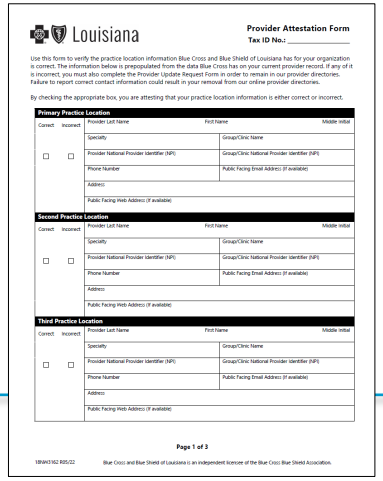
Our Provider Credentialing & Data Management team will work with you to help ensure your information is current and accurate.

Provider Attestation Form

- Due to requirements of the federal Consolidated Appropriation Acts (CAA) 2021, our PCDM Department is sending a Provider Attestation Form every 90 days to all providers listed in our online provider directories to review their information as it appears in our directories.

- If any of your information is not correct, there will be an option within the Provider Attestation Form to complete and return our Provider Update Request Form. This allows us to update the information we publish in our directories.

- The form is emailed in a DocuSign format, prepopulated with the information we have on file. The provider must verify and attest to the accuracy of the information.



Louisiana

Provider Attestation Form

Tax ID No.: _____

Use this form to verify the practice location information Blue Cross and Blue Shield of Louisiana has for your organization is correct. The information below is prepopulated from the data Blue Cross has on your current provider record. If any of it is incorrect, you must also complete the Provider Update Request Form in order to remain in our provider directories. Failure to report correct contact information could result in your removal from our online provider directories.

By checking the appropriate box, you are attesting that your practice location information is either correct or incorrect.

Primary Practice Location

Correct	Incorrect	Provider Last Name	First Name	Middle Initial
☐	☐	Specialty		Group/Clinic Name
		Provider National Provider Identifier (NPI)		Group/Clinic National Provider Identifier (NPI)
		Phone Number		Public Facing Email Address: (if available)
		Address:		
		Public Facing Web Address: (if available)		

Second Practice Location

Correct	Incorrect	Provider Last Name	First Name	Middle Initial
☐	☐	Specialty		Group/Clinic Name
		Provider National Provider Identifier (NPI)		Group/Clinic National Provider Identifier (NPI)
		Phone Number		Public Facing Email Address: (if available)
		Address:		
		Public Facing Web Address: (if available)		

Third Practice Location

Correct	Incorrect	Provider Last Name	First Name	Middle Initial
☐	☐	Specialty		Group/Clinic Name
		Provider National Provider Identifier (NPI)		Group/Clinic National Provider Identifier (NPI)
		Phone Number		Public Facing Email Address: (if available)
		Address:		
		Public Facing Web Address: (if available)		

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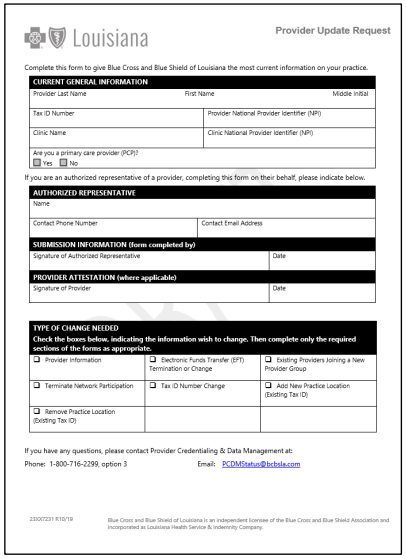
Providers who do not complete attestation of their information will be removed from our online provider directories.

How to Update Your Information

It is important that we always have your most current information. Our revised **Provider Update Request Form** now accommodates all your change requests, which are handled directly by our Provider Data Management team.



Louisiana

Provider Update Request

Complete this form to give Blue Cross and Blue Shield of Louisiana the most current information on your practice.

CURRENT GENERAL INFORMATION

Provider Last Name | First Name | Middle Initial

Tax ID Number | Provider National Provider Identifier (NPI)

Clinic Name | Clinic National Provider Identifier (NPI)

Are you a primary care provider (PCP)?
☐ Yes ☐ No

If you are an authorized representative of a provider, completing this form on their behalf, please indicate below.

AUTHORIZED REPRESENTATIVE

Name

Contact Phone Number | Contact Email Address

SUBMISSION INFORMATION (form completed by)

Signature of Authorized Representative | Date

PROVIDER ATTESTATION (where applicable)

Signature of Provider | Date

TYPE OF CHANGE NEEDED

Check the boxes below, indicating the information wish to change. Then complete only the required sections of the forms as appropriate.

☐ Provider Information	☐ Electronic Funds Transfer (EFT) Termination or Change	☐ Existing Providers Joining a New Provider Group
☐ Terminate Network Participation	☐ Tax ID Number Change	☐ Add New Practice Location (Existing Tax ID)
☐ Remove Practice Location (Existing Tax ID)		

If you have any questions, please contact Provider Credentialing & Data Management at:
Phone: 1-800-716-2299, option 3 Email: PCDMStatus@bcbsla.com

23007231 R10/19

Blue Cross and Blue Shield of Louisiana is an independent licensee of the Blue Cross and Blue Shield Association and incorporated as Louisiana Health Service & Indemnity Company.

When you access the form, check the appropriate box to indicate the type of change needed. You may select more than one option.

- **Provider Information** allows you to update your address, phone, fax, email address, hours of operation and more.
- **EFT Termination or Change** option is to update your EFT information.
- **Existing Providers Joining a New Provider Group** is used to link an individual provider to an existing provider group or clinic.
- **Terminate Network Participation** is to request termination from one or more of our networks.
- **Tax ID Number Change** is to report a change in your Tax ID number.
- **Add a New Practice Location** is for when a provider is adding practice location(s) on an existing Tax ID.
- **Remove Practice Location** is for when a provider is removing a practice location(s) on an existing Tax ID.

This form link is available online at **www.bcbsla.com/providers** >Resources >Forms.

Provider Update Request Form

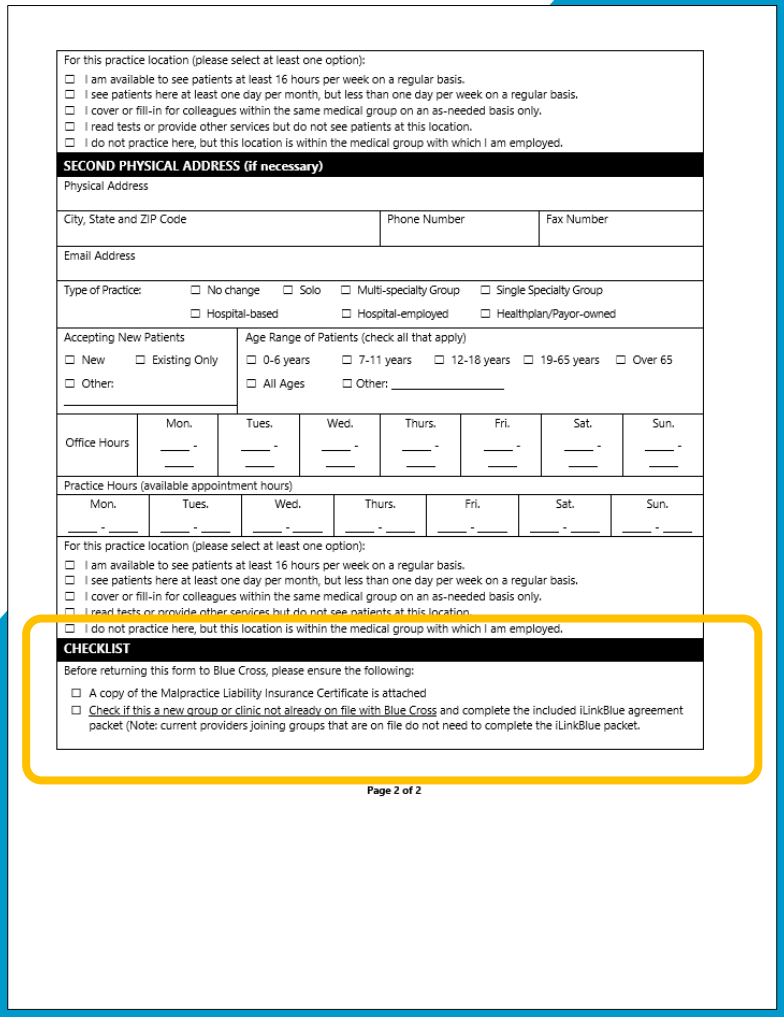
- Indicate on the Provider Request Form they type of change you are requesting.
- You will **only** need to fill out the section of this form that needs updating. Filling out the entire form is not required.

TYPE OF CHANGE **Check all applicable boxes below to indicate the information you wish to change. This allows you to complete the required sections of the forms, as appropriate.**		
☐ Demographic Information	☐ Electronic Funds Transfer (EFT) Termination or Change (*does not apply for Blue Advantage EFT update*)	☐ Existing Providers Joining a New Provider Group (*includes solo providers creating a new provider group*)
☐ Termination Request	☐ Tax ID Number Change	☐ Add New Practice Location (Existing Tax ID)
☐ Remove Practice Location (Existing Tax ID)		

Provider Update Request Form

Complete the checklist:

- Some changes on our **Provider Update Request Form** include a checklist of **required** supporting documentation needed to complete your request.
- Please ensure **all** requested items on the checklist are included or completed before submitting.
- Submissions that are missing checklist items will be returned.



For this practice location (please select at least one option):

- ☐ I am available to see patients at least 16 hours per week on a regular basis.
- ☐ I see patients here at least one day per month, but less than one day per week on a regular basis.
- ☐ I cover or fill-in for colleagues within the same medical group on an as-needed basis only.
- ☐ I read tests or provide other services but do not see patients at this location.
- ☐ I do not practice here, but this location is within the medical group with which I am employed.

SECOND PHYSICAL ADDRESS (if necessary)

Physical Address

City, State and ZIP Code | Phone Number | Fax Number

Email Address

Type of Practice: ☐ No change ☐ Solo ☐ Multi-specialty Group ☐ Single Specialty Group ☐ Hospital-based ☐ Hospital-employed ☐ Healthplan/Payor-owned

Accepting New Patients: ☐ New ☐ Existing Only ☐ Other:

Age Range of Patients (check all that apply): ☐ 0-6 years ☐ 7-11 years ☐ 12-18 years ☐ 19-65 years ☐ Over 65 ☐ All Ages ☐ Other: _____

Office Hours	Mon.	Tues.	Wed.	Thurs.	Fri.	Sat.	Sun.
	___ - ___	___ - ___	___ - ___	___ - ___	___ - ___	___ - ___	___ - ___

Practice Hours (available appointment hours)

Mon.	Tues.	Wed.	Thurs.	Fri.	Sat.	Sun.
___ - ___	___ - ___	___ - ___	___ - ___	___ - ___	___ - ___	___ - ___

For this practice location (please select at least one option):

- ☐ I am available to see patients at least 16 hours per week on a regular basis.
- ☐ I see patients here at least one day per month, but less than one day per week on a regular basis.
- ☐ I cover or fill-in for colleagues within the same medical group on an as-needed basis only.
- ☐ I read tests or provide other services but do not see patients at this location.
- ☐ I do not practice here, but this location is within the medical group with which I am employed.

CHECKLIST

Before returning this form to Blue Cross, please ensure the following:

- ☐ A copy of the Malpractice Liability Insurance Certificate is attached
- ☐ Check if this a new group or clinic not already on file with Blue Cross and complete the included iLinkBlue agreement packet (Note: current providers joining groups that are on file do not need to complete the iLinkBlue packet.

Page 2 of 2

Provider Credentialing & Data Management (PCDM)

Provider Network Setup, Credentialing, Contracting & Demographic Change

Vielka Valdez, Director, Provider Network Operations
vielka.valdez@bcbsla.com

Kaci Guidry, Manager, Provider Credentialing and Data Management
kaci.guidry@bcbsla.com

Kristin Ross, Manager, Provider Contract Administration
kristin.ross@bcbsla.com

Chrisy Cavalier, Supervisor, Provider Information (PCDM Status)
chrisy.cavalier@bcbsla.com

If you would like to check the status on your credentialing application or provider data change or update, please contact the Provider Credentialing & Data Management Department by emailing **PCDMstatus@bcbsla.com** or by calling 1-800-716-2299, option 2.

ADDRESSING YOUR

At this time, we will address the questions you submitted electronically through the webinar platform.

You may also email questions after the webinar to provider.relations@bcbsla.com.