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.

Louisiana

CREDENTIALING, CONTRACTING, RECREDENTIALING & DATA MANAGEMENT

September 2023

Presented by:

Melonie Martin
provider relations representative

Vantage is a Louisiana-based company that is partnered with Blue Cross and Blue Shield of Louisiana, including HMO Louisiana, Inc., to credential and recredential our network providers.

DocuSign® is an independent company that Blue Cross and Blue Shield of Louisiana uses to enable providers to sign and submit provider credentialing and data management forms electronically.

WELCOME!

- ✓ Today's presentation will take you on a journey through the **credentialing** and **recredentialing** processes.
- ✓ We will also explain the network **contracting** process.
- ✓ We will show you how to update and **manage the data** Blue Cross has on your provider record.

THE BASICS

Credentialing Is Required for Network Participation

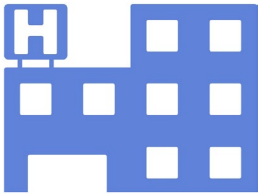
- Blue Cross and Blue Shield of Louisiana credentials all practitioners and facilities that participate in our networks.
- We partner with **Vantage Health Plan** and **symplrCVO** to conduct credentialing verification processes for our commercial and Blue Advantage networks.

THE BASICS

We credential **professional**

&

facility providers



Credentialing Is Required for Network Participation

- Since 1996, Blue Cross fully credentials providers who apply for network participation.
- Our credentialing program is accredited by the Utilization Review Accreditation Commission (URAC).
- Providers must meet certain criteria as regulated by our accreditation body and the Blue Cross Blue Shield Association.

THE BASICS

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

network participating provider record

Contract on File
&
Provider **IS** credentialed

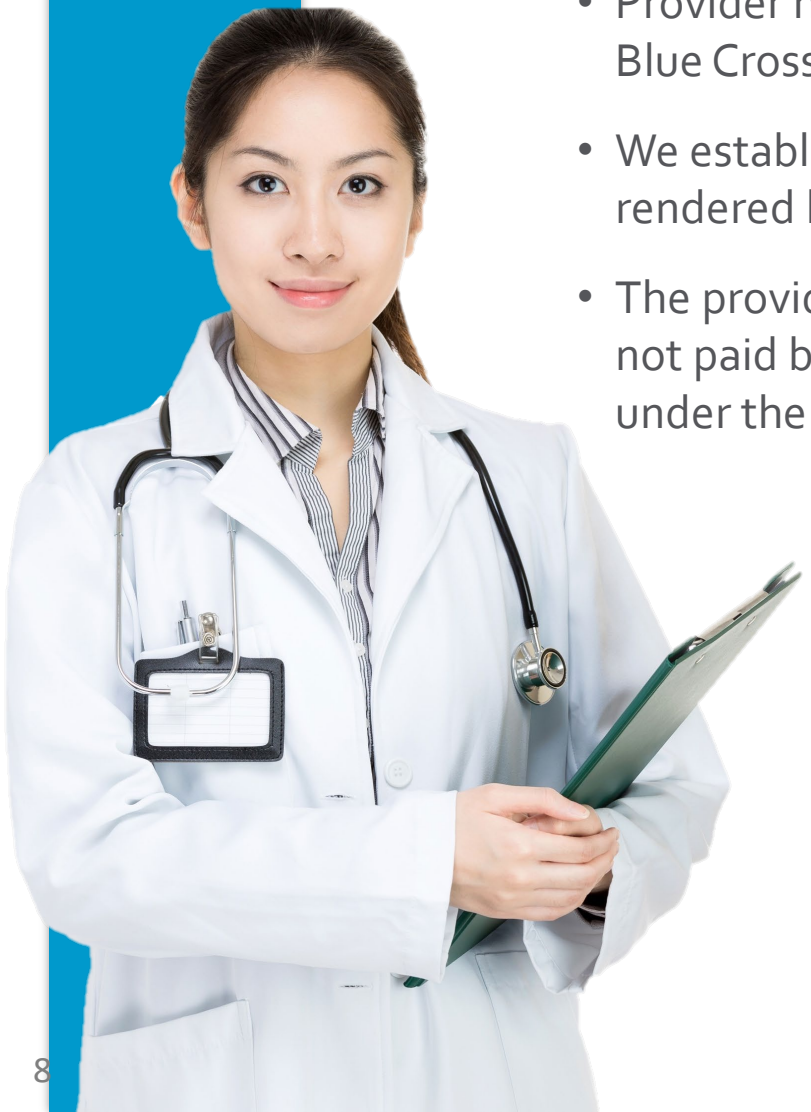
non-participating provider record
(for filing claims only)

No Contract
&
Provider **IS NOT** credentialed

What is a 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**).

What is a 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.

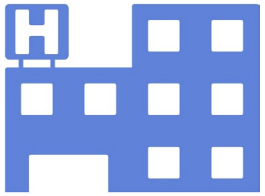
Applying for Credentialing

Professional Provider Network Availability

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.

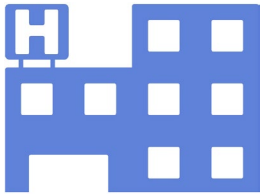


Facility Network Availability

The following facility types must meet certain criteria 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 types at **www.bcbsla.com/providers** >Network Enrollment >Join Our Networks > Facilities and Hospitals >Credentialing Process.



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.

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

TELEHEALTH ONLY PROVIDERS

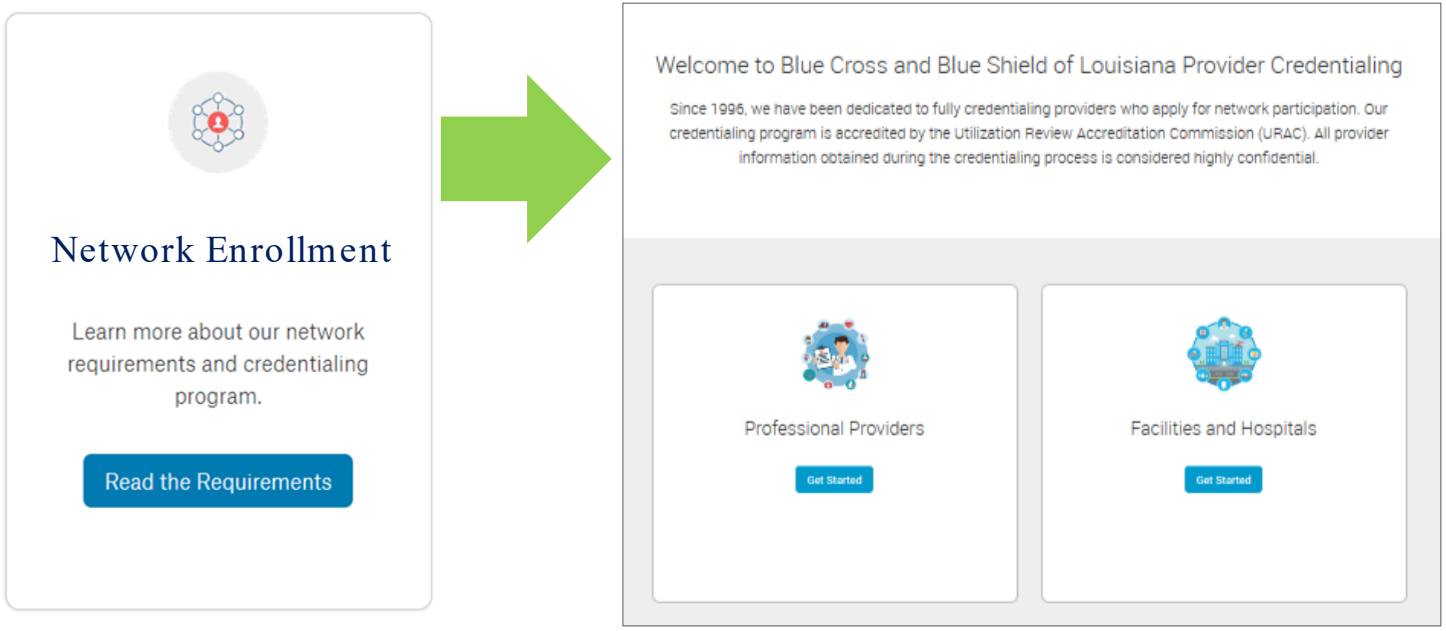
Our credentialing policy includes guidance for the provision of telehealth services to our members **WHEN**:

- Louisiana-based, in-network provider
  - Must be in process of or have completed credentialing/contracting to participate in our network.
  - Must be employed or affiliated with a physical practice located in Louisiana.
- 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.

THE PAPERWORK

You **MUST** complete and submit documentation to start the process for credentialing **OR** to obtain a provider record.

Applications are available online at **www.bcbsla.com/providers**.



Choose **Network Enrollment**, then **Join Our Networks** page then, select **Professional Providers** or **Facilities and Hospitals** to find credentialing packets.

THE PAPERWORK for professional providers

Overview | Credentialing Process | Join Our Networks | Update Your Information | FAQs

Join Our Networks

Your request can take up to 90 days to process once all required information has been received. The BCBSLA Welcome to the Network notification letter will notify you of next steps and your network participation effective date shall be the effective date indicated on the signature page of your provider agreement. BCBSLA does not backdate network participation. Any claims submitted prior to network participation will process as out-of-network. When a claim is processed as out-of-network, payment for services may go to the member not to the provider.

Applying for network participation has been made easy. Our online applications can now be completed, signed and submitted digitally with **DocuSign.** Each packet includes a checklist of all required documents. Please follow that checklist to ensure all information is included with the submission of your application. Blue Cross uses the LSCA for both credentialing and recredentialing applications.

Professional Initial Credentialing Packet

The Professional (initial) credentialing packet includes a checklist of all required documents.

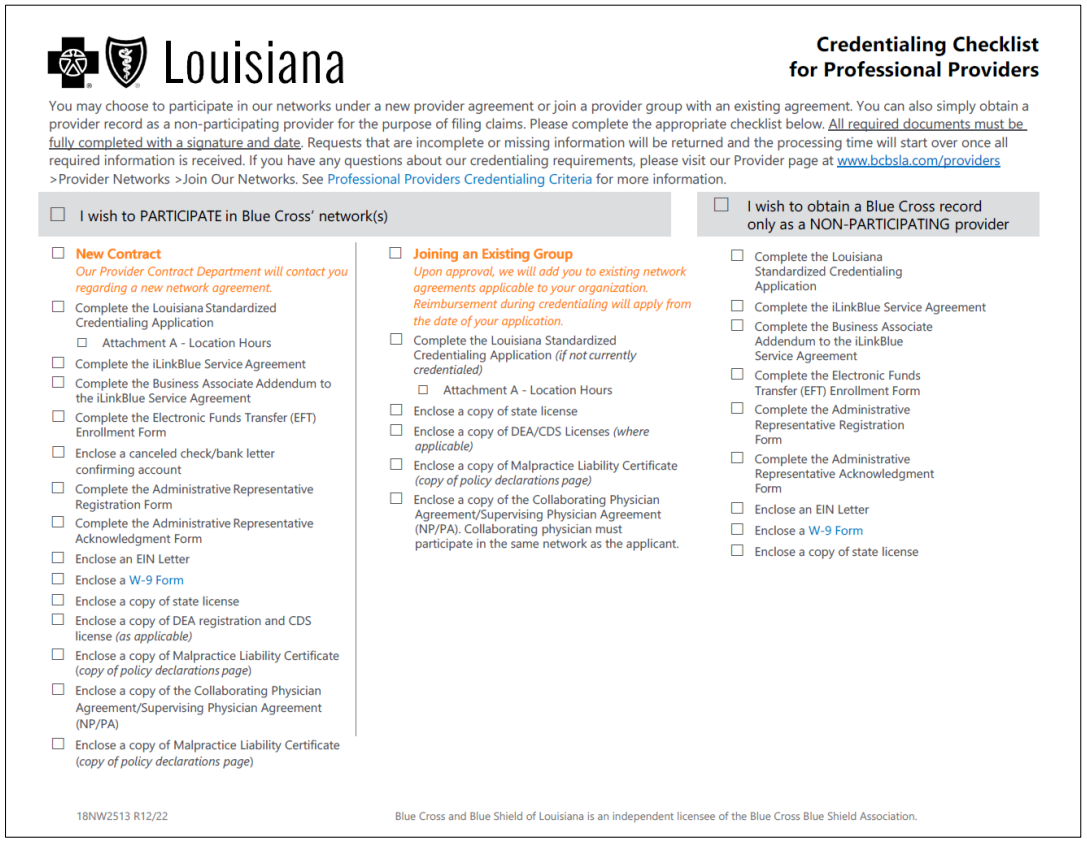
- To **join our networks through a new contract**, or **joining an existing group**, complete the checklist under "I wish to PARTICIPATE in Blue Cross' network(s)."
- If you **want a provider record only for filing claims**, complete the checklist under "I wish to obtain a Blue Cross record only as a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

THE PAPERWORK for professional providers

Professional Initial Credentialing Packet

This Packet is in **DocuSign®** to be completed, signed and submitted digitally.

The **Checklist** must be completed.



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

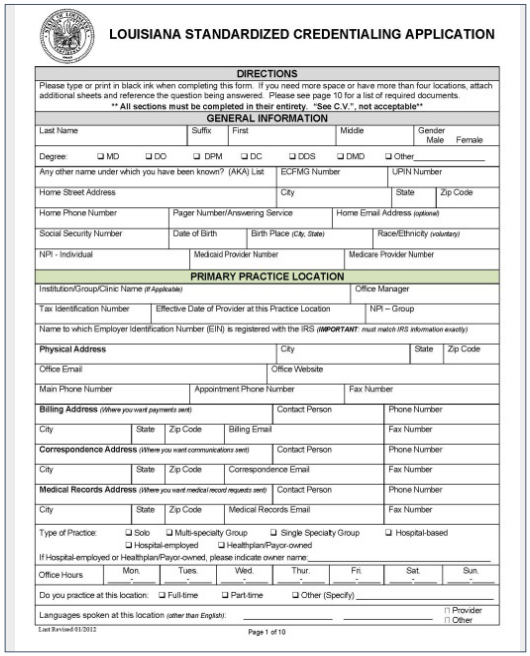
18NW2513 R12/22

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

- Submit all the indicated documents.
- Incomplete credentialing packets (missing information or submitted incorrectly) may be returned. A letter is sent advising of the missing information and how to resubmit.

THE PAPERWORK 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.

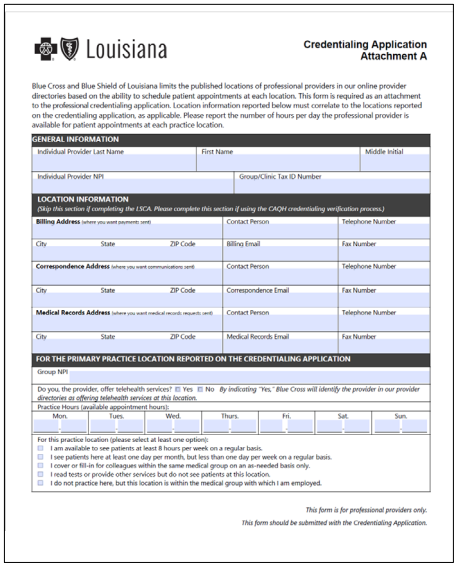
Do you practice at this location: ❑ Full-time ❑ Part-time ❑ Other (Specify) _____

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

Last Revised 01/2012 Page 1 of 10

The **LSCA Attachment A** is to report the hours per day the professional provider is available for patient appointments at each practice location.

- Location information reported must correlate to the locations reported on the LSCA, as applicable.
- This form is also used to 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.

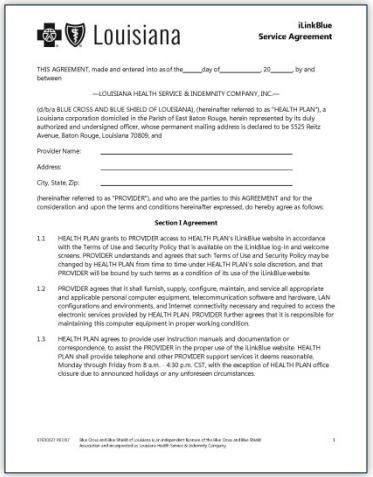
This form is for professional providers only.

This form should be submitted with the Credentialing Application.

To be listed in the directory, provider must be available to schedule patient appointments **a minimum of 8 hours per week** at the location listed.

THE PAPERWORK for professional providers

The **iLinkBlue Application Packet** is part of our credentialing packet and must be completed.


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:

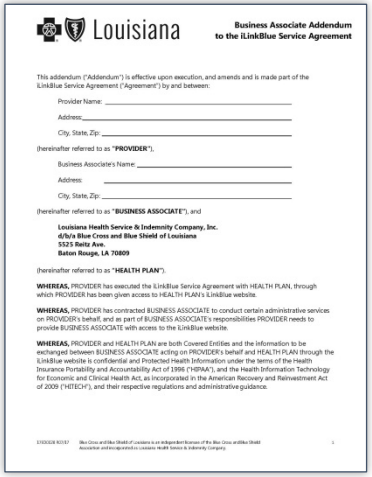
Section I Agreement

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

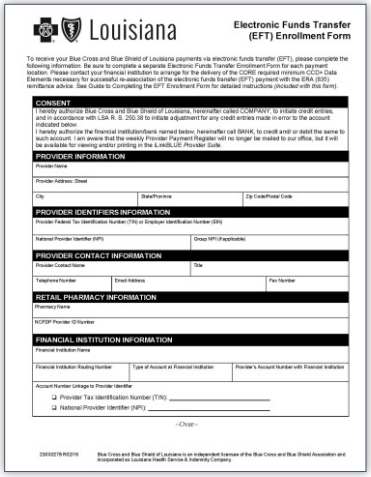
(hereinafter referred to as "**HEALTH PLAN**").

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

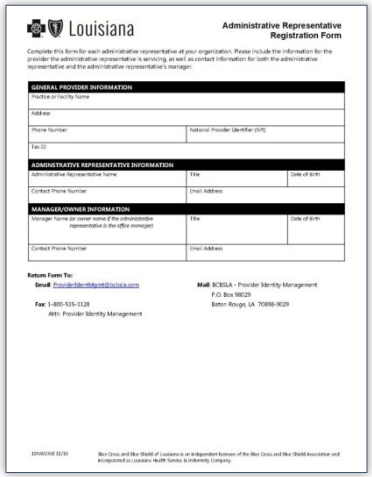
Financial Institution Routing Number | Type of Account at Financial Institution | Provider's Account Number with Financial Institution

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: 1-800-535-1128
Attn: Provider Identity Management

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

Administrative Representative Registration Form

iLinkBlue Service Agreement

Business Associate Addendum

Electronic Funds Transfer (EFT) Enrollment Form

Administrative Representative Registration Form

iLinkBlue is our secure online provider tool. It is your source for eligibility, benefits, claims filing, claims research, payment queries, authorization requests and more.

www.bcbsla.com/ilinkblue

THE PAPERWORK for facilities

Overview | Credentialing Process | **Join Our Network** | Update Your Information | Frequently Asked Questions

Join Our Network

Your request can take up to 90 days to process once all required information has been received. The BCBSLA Welcome to the Network notification letter will notify you of next steps and your network participation effective date shall be the effective date indicated on the signature page of your provider agreement. BCBSLA does not backdate network participation. Any claims submitted prior to network participation will process as out-of-network. When a claim is processed as out-of-network, payment for services may go to the member not to the provider.

Applying for network participation has been made easy. Our online Facility Initial Credentialing packet can now be completed, signed and submitted digitally with **DocuSign.** Each packet includes a checklist of all required documents. Please follow that checklist to ensure all information is included with the submission of your application.

Facility Initial Credentialing Packet

Some of the required credentialing supporting documentation for Facilities and Hospitals includes:

- Health Delivery Organization (HDO) Form
- HDO Attachment, as applicable
- State License
- Malpractice Liability Certificate (copy of declarations page)

Network facilities and hospitals are reverified every three years from their last credentialing acceptance date. Blue Cross sends reverification packets directly to facilities and hospitals based on the correspondence information on file.

The Facility Initial Credentialing Packet includes a checklist of all required documents needed for credentialing.

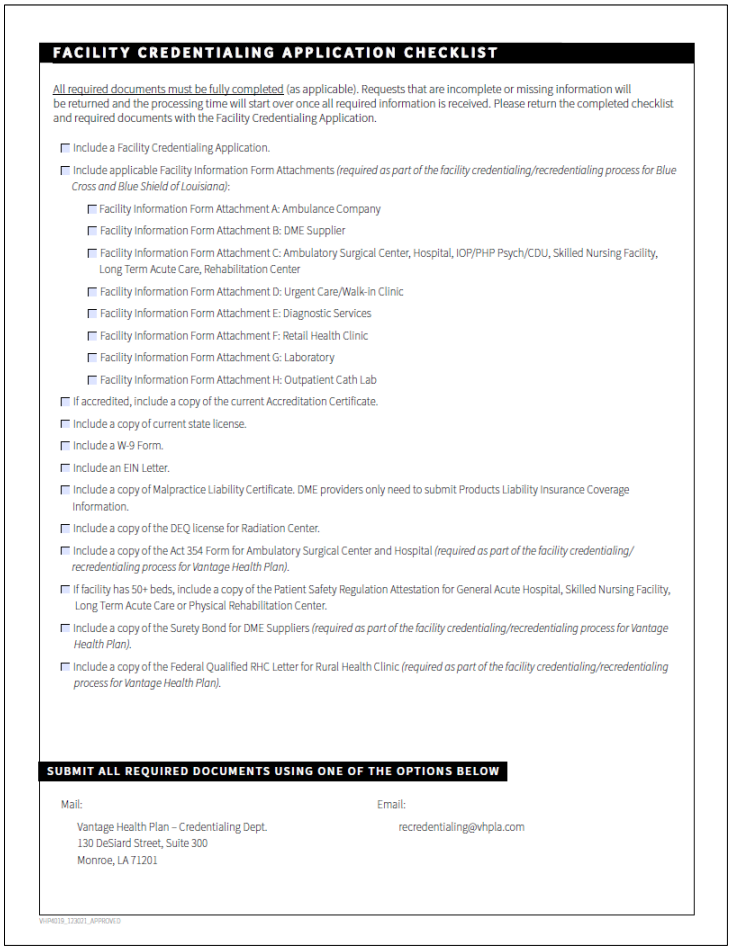
THE PAPERWORK for facilities

Facility Initial Credentialing Packet

This Packet is in **DocuSign®** to be completed, signed and submitted digitally.

The **Checklist** must be completed.

- Submit all indicated documents.
- Incomplete credentialing packets (missing information or submitted incorrectly) may be returned. A letter is sent advising of the missing information and how to resubmit.



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).*

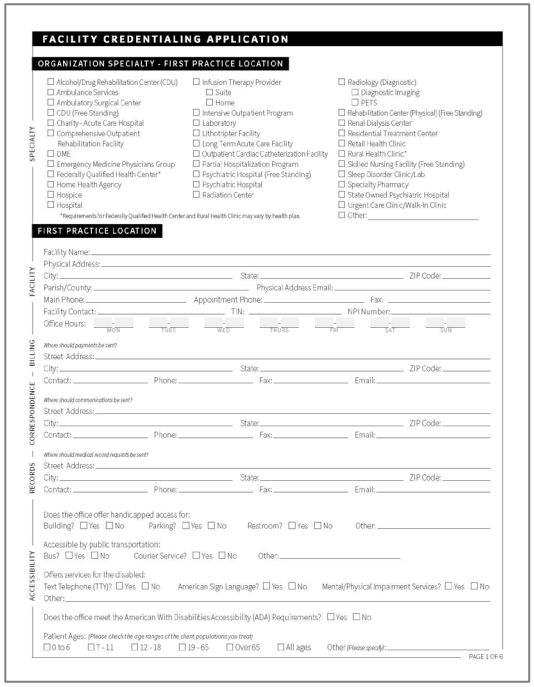
SUBMIT ALL REQUIRED DOCUMENTS USING ONE OF THE OPTIONS BELOW

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

Email:
recredentialing@vhpla.com

THE PAPERWORK for facilities

Blue Cross uses the **Facility Credentialing Application** for initial credentialing.



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

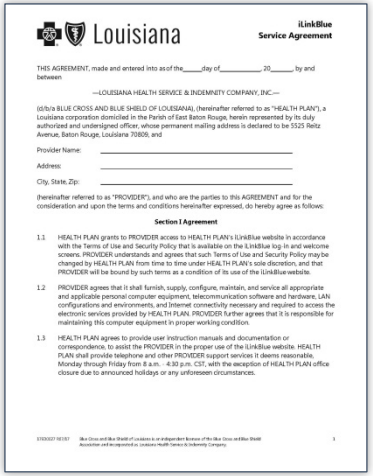
There are attachment forms included with the main credentialing form. Facilities should complete only those that apply.

- Attachment A – Ambulance
- Attachment B – DME Supplier
- Attachment C – ASC, Hospital, IOP, PHP, Psych, CDU, SNF, LTAC, Rehab
- Attachment D – Urgent Care, Walk-in Clinic
- Attachment E – Diagnostic Services
- Attachment F – Retail Health Clinic
- Attachment G – Laboratory
- Attachment H – Outpatient Cath Lab

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

THE PAPERWORK for facilities

The **iLinkBlue Application Packet** is part of our credentialing packet and must be completed.


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: _____

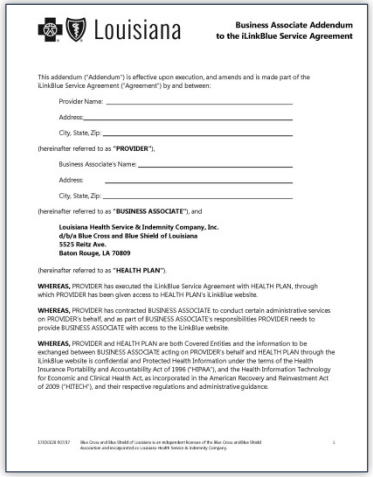
(hereinafter referred to as "PROVIDER"), and who are the parties to this AGREEMENT and for the consideration and upon the terms and conditions hereinafter expressed, do hereby agree as follows:

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.


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

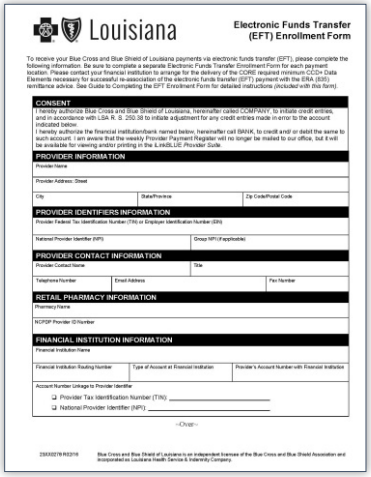
Louisiana Health Service & Indemnity Company, Inc.
d/b/a Blue Cross and Blue Shield of Louisiana
5525 Reitz Ave.
Baton Rouge, LA 70809

(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.


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

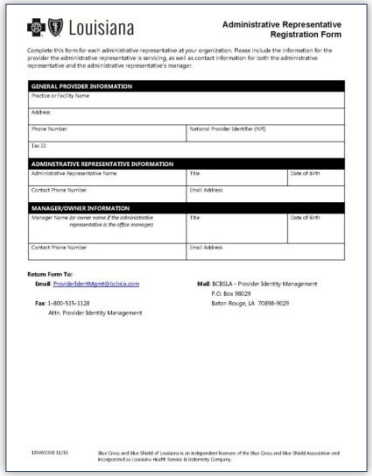
RETAIL PHARMACY INFORMATION

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—


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: 1-800-535-1128
Attn: Provider Identity Management

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

iLinkBlue Service Agreement

Business Associate Addendum

Electronic Funds Transfer (EFT) Enrollment Form

Administrative Representative Registration Form

iLinkBlue is our secure online provider tool. It is your source for eligibility, benefits, claims filing, claims research, payment queries, authorization requests and more.

www.bcbsla.com/ilinkblue

Let's Get Credentialed

THE CREDENTIALING PROCESS

- 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.

To inquire about the status of your initial credentialing application, you may send and email to **PCDMstatus@bcbsla.com**.

VERIFYING YOUR INFORMATION

We partner with **Vantage Health Plan (VHP)** and **symplrCVO**, to assist with the primary source verification of our credentialing and recredentialing applications.

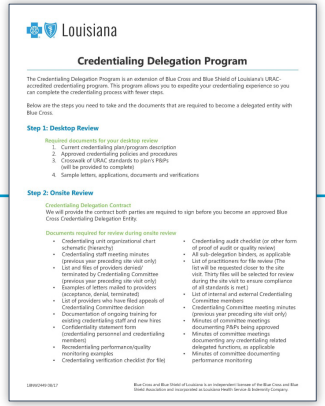
Providers in the credentialing and recredentialing process may be directly contacted by VHP or symplrCVO to verify application details and supporting documentation.

VHP and symplrCVO make three attempts to contact the provider. If unsuccessful, the credentialing process is stopped, and the application is rejected. For providers in the recredentialing process, network participation may be terminated.

If you have questions about this process, you may email our Provider Relations Department at **provider.relations@bcbsla.com**.

CREDENTIALING DELEGATION PROGRAM

- It is an extension of our accredited credentialing program and is available to groups **with 50 or more practitioners**.
- 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.
- 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.


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 Credentialing Committee decision (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 Blue Cross requested closure date will be 75 days, and 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

LBWG9439 08/17

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.

If you have any questions about the Credentialing Delegation Program, please email **credentialing.delegation@bcbsla.com**.

The *Credentialing Delegation Program* guide explains the steps network provider groups must take and the documents required to become a delegated entity. It is sent to providers requesting to join the program.

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**. That contracted group must have the **same provider type contract** on file with Blue Cross. This allows for in-network reimbursement on submitted claims during the credentialing process. Reimbursement during credentialing is backdated one month prior to the date of application receipt.

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, send an email to **PCDMstatus@bcbsla.com**.

Expedited Processing (Louisiana Law, Act 897)

In addition to reimbursement during credentialing, Act 897 allows providers a 30-day expedited application for reimbursement during credentialing.

To qualify for the expedited time frame, providers must meet the following requirements:

- Provider must have admitting privileges to a network hospital or an approved exception. Provider must list this information in the hospital affiliations section on the appropriate credentialing application.
- Must have the same provider type agreement on file with Blue Cross (e.g., physician, allied health, facility, dental agreements).
- Agrees to hold our members harmless for payments above the allowable amount.

Requesting expedited processing:

Include with the initial credentialing application via DocuSign:

- Letter asking Blue Cross to invoke the expedited process.
  - The letter must include your agreement to hold our members harmless for payments above the allowable amount.
  - The letter must be on company letterhead and signed by the provider.
- Signed admitting privileges agreement to a network hospital.

Example Letter to Blue Cross

The Letter, included in the initial credentialing application via DocuSign, must:

- Ask Blue Cross to invoke the Louisiana law that extends existing requirements for credentialing of physicians to all health care providers;
- Include your agreement to hold our members harmless for payments above the allowable amount;
- Be on letterhead and signed by the provider.

Sample Letter

{Date}

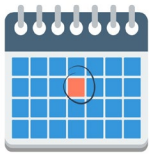
Dear Blue Cross and Blue Shield of Louisiana:

In accordance with the Louisiana law extending certain requirements for credentialing of physicians to all health care providers, please accept this written request to reimburse ***{provider's name}*** *for services provided as a new provider at* ***{provider's group name}*** *at our group contract rate and with in-network benefits.* ***{Provider's group name}*** *agrees that all contract provisions, including holding covered members harmless for charges beyond the Blue Cross allowable amount and the member's cost share amount (deductible, coinsurance and/or copayment, as applicable) will apply to the new provider.*

{Signature of the provider}

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 departments.



EFFECTIVE DATES

For non-participating providers (requesting a provider record only), Blue Cross allows an effective date up to two years back for providers who want a provider record only for filing claims.

For participating providers, Blue Cross cannot retroactively allow network participation prior to a provider's credentialing date. Our accrediting organization strictly prohibits it. Effective dates are based on:

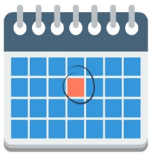
Delegation Program Providers	New Providers Not Credentialed	Providers Already Credentialed
The effective date for delegated providers is based on approval of the Credentialing Delegation spreadsheet by our Medical Director.	If you are eligible for reimbursement during credentialing (joining an existing 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.

Signing the Contract

NETWORK AGREEMENT (the final paperwork)

Once the credentialing process is completed, the next step in the process is to ensure the provider has a signed network agreement.

Our Provider Contracting representatives will work with the provider for the appropriate networks available for participation. Providers remain non-participating in our networks until a signed agreement is received by our Contracting Department.



The signed network agreement will include the effective date of network participation, which will be the date of approval from the Credentialing Committee.

If you have any questions about the contracting process, send an email to **provider.contracting@bcbsla.com**.

THE NETWORK AGREEMENT the final paperwork

Professional providers who are new to the network may not always be required to sign a contract.

new agreement **IS REQUIRED** when:

- Newly credentialed solo practitioners
- Newly credentialed providers joining a group not currently participating with Blue Cross
- Newly credentialed providers joining a participating group that does not have an agreement on file for the provider type:

  Example 1: a nurse practitioner (NP) joins a participating physician group (only has a physician agreement on file). The group must sign an allied agreement to cover the NP.

  Example2: a physician joins a participating allied group (only has an allied agreement on file). The group must sign a physician agreement.

- **Some** participating providers, groups or facilities changing Tax ID number (TIN). *This is outlined on Slide 45.*

THE NETWORK AGREEMENT the final paperwork

Professional providers who are new to the network may not always be required to sign a contract.

new agreement **IS NOT REQUIRED** when:

- A newly credentialed physician and/or allied provider joins a participating group that already has the applicable physician and/or allied agreement on file.

- A newly credentialed physician and/or allied provider joining a participating group, through Blue Cross' Delegated Credentialing Agreement program **and** that group has the applicable physician and/or allied agreement on file.

Staying in the Network

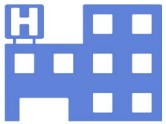
RECREDENTIALING

The Credentialing Committee reviews all recredentialing applications.

Network providers must be approved through our **recredentialing** process **every three years** (or within 1 year in some cases) from the last credentialing acceptance date. Blue Cross is partnered with Vantage and symplrCVO to recredential our network providers. Vantage sends* recredentialing applications to providers approximately 6 months prior to their recredentialing due date. Instructions are included on how to return completed forms. Vantage, symplrCVO or Blue Cross will complete the verification process.

Required applications:

professional providers: Louisiana Standardized Credentialing Application (LSCA) **or** CAQH Application or



facilities: Facility Credentialing Application and any applicable application attachments

If you have questions during the process, you may email recredentialing@vhpla.com or call (318) 807-4755.

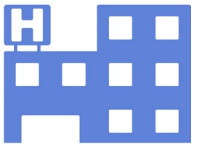
**The provider's correspondence record information is used when sending recredentialing applications.*

RECREDENTIALING

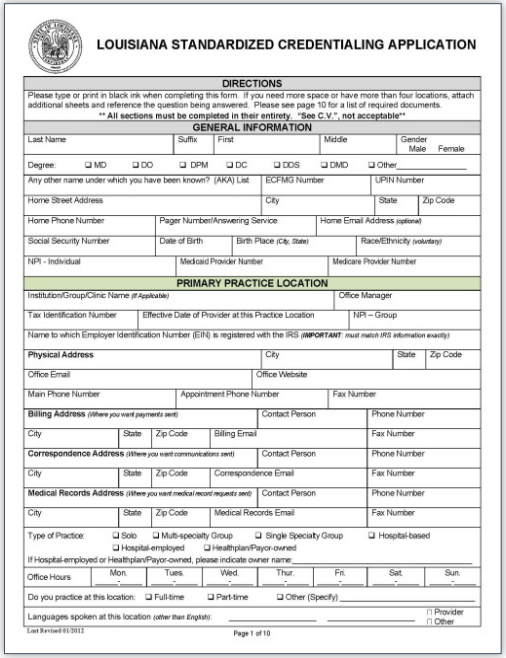
Vantage accepts the following forms for recredentialing.

professional

OR



facility



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

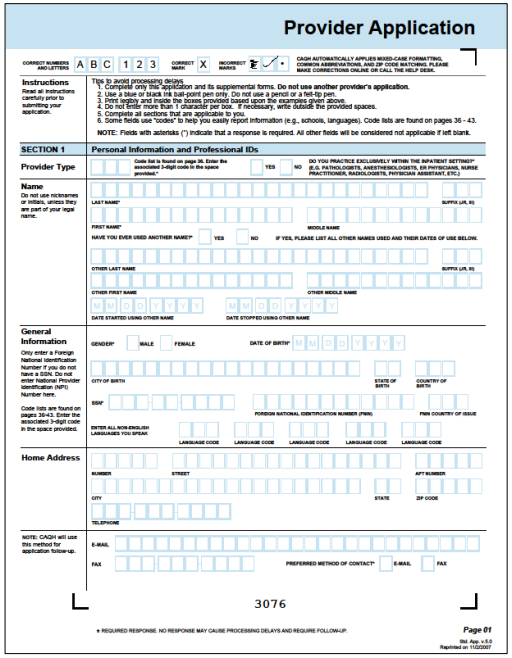
Type of Practice: ❑ Solo ❑ Multi-specialty Group ❑ Single Specialty Group ❑ Hospital-based
❑ Hospital-employed ❑ Healthplan/Payor-owned
If Hospital-employed or Healthplan/Payor-owned, please indicate owner name:

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):

Last Revised 01/2012 Page 1 of 10



Provider Application

Instructions
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 enter 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

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

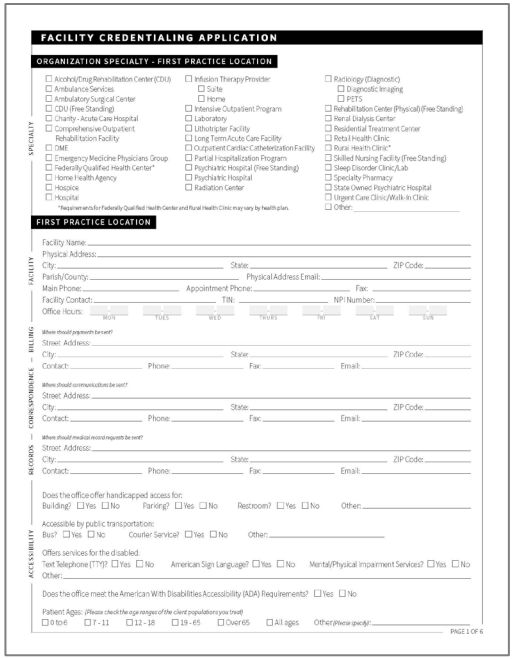
Home Address

NOTE: CAQH will use this method for application follow-up.

3076

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

Page 01



FACILITY CREDENTIALING APPLICATION

ORGANIZATION SPECIALTY - FIRST PRACTICE LOCATION

SPECIALTY

FACILITY

BILLING

CORRESPONDENCE

RECORDS

ACCESSIBILITY

FIRST PRACTICE LOCATION

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

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

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

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

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):

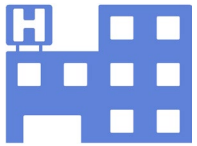
PAGE 1 OF 6

If information is missing from submitted recredentialing application, the provider is then contacted by a recredentialing specialist with a deadline to return the needed information. If not received timely then provider may be terminated from the network.

SUPPORTING DOCUMENTATION NEEDED FOR RECREDENTIALING PROCESS

professional

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



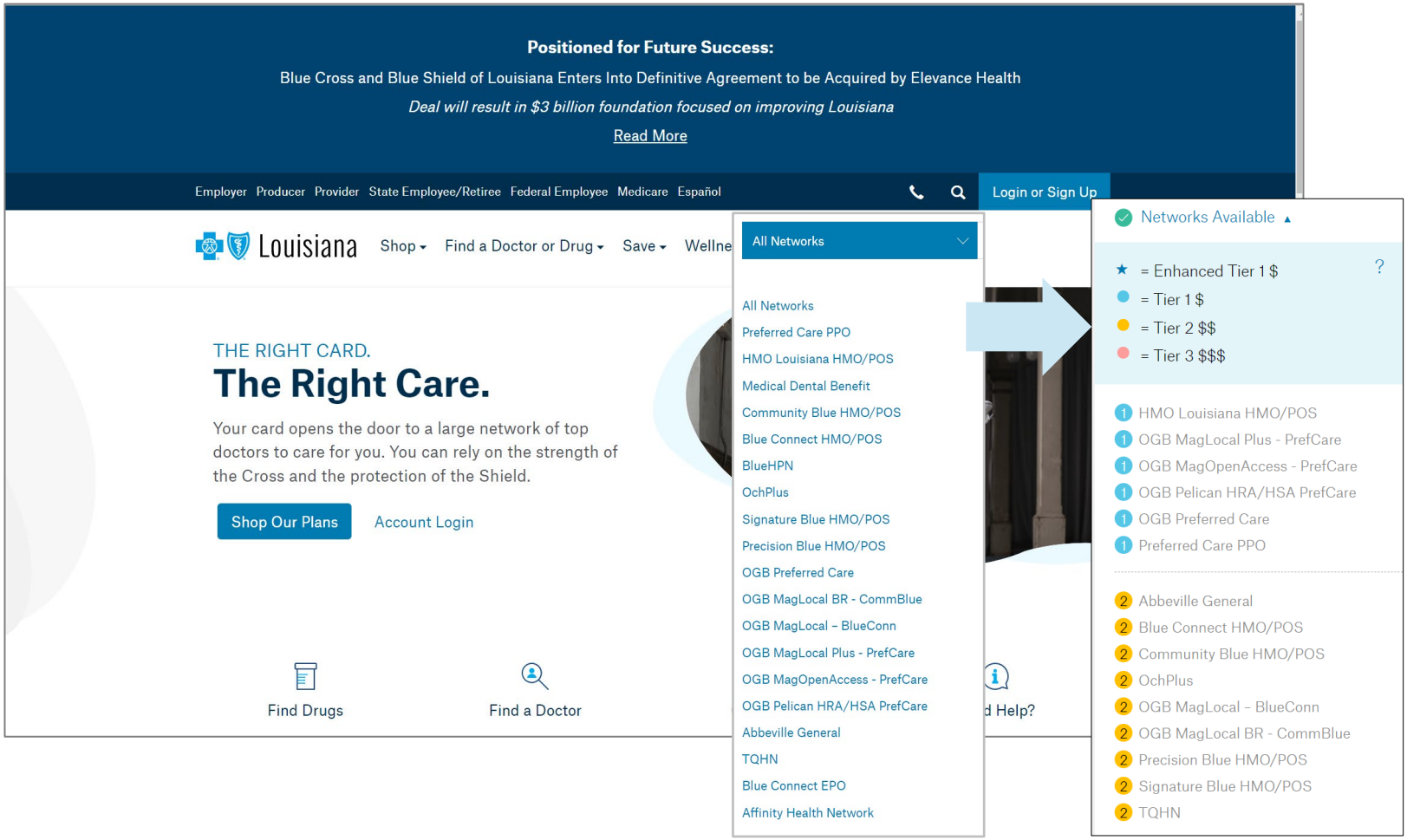
facility

- Completed credentialing form
- Completed attachment(s), as applicable
- Copy of state license
- Copy of W-9
- Copy of Malpractice Liability Certificate (copy of policy declarations page)

How Members Find You

ONLINE PROVIDER DIRECTORIES

www.bcbsla.com >Find a Doctor or Drug >Local Provider Directory



ONLINE PROVIDER DIRECTORIES

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**.

- Addresses (location information)
- Phone numbers
- Accepting new patients
- Providers working at certain locations
- Information about telehealth services

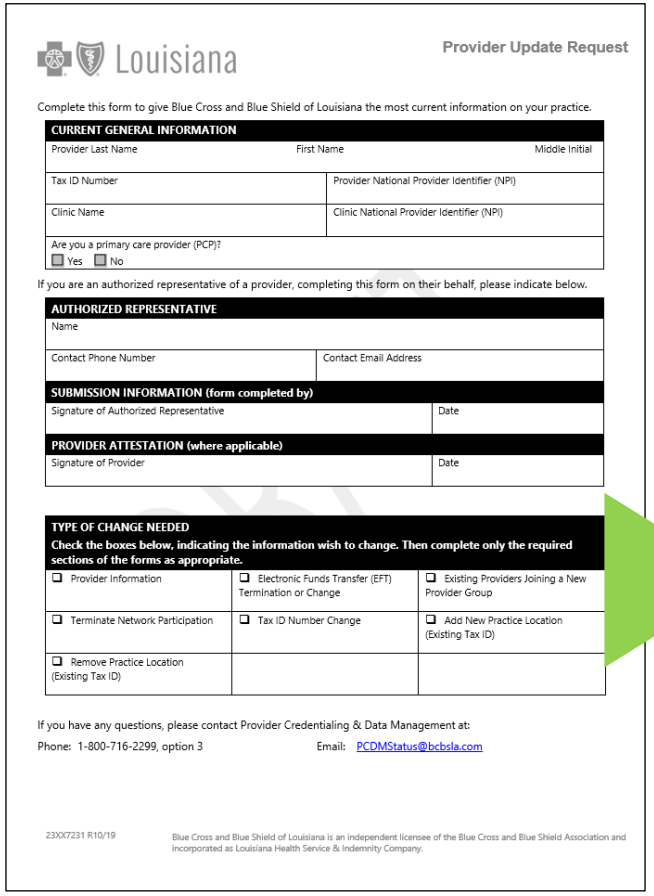
For professional providers to be listed in our directories, they must be available to schedule patients' appointments a **minimum of 8 hours per week** at the location listed.

It is the contractual responsibility of all participating providers keep their information current with Blue Cross. To report changes in your information, use the **Provider Update Request Form**. Our Provider Credentialing & Data Management Department will work with you to help ensure your information is current and accurate.

UPDATING YOUR INFORMATION

It is important that we always have your most current information!

Our **Provider Update Request Form** 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

23XX7231 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.

This form allows you to make any of the following changes. Simply check the appropriate box(es) to indicate the type of change needed. You may select more than one option.

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	☐ 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)		

The form is available online at www.bcbsla.com/providers >Resources >Forms.

UPDATING YOUR INFORMATION

It is important that we always have your most current information!

- 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. Completing 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	☐ 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)		

UPDATING YOUR INFORMATION

It is important that we always have your most current information!

Our **Provider Update Request Form** accommodates these change requests:

- ✓ **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.

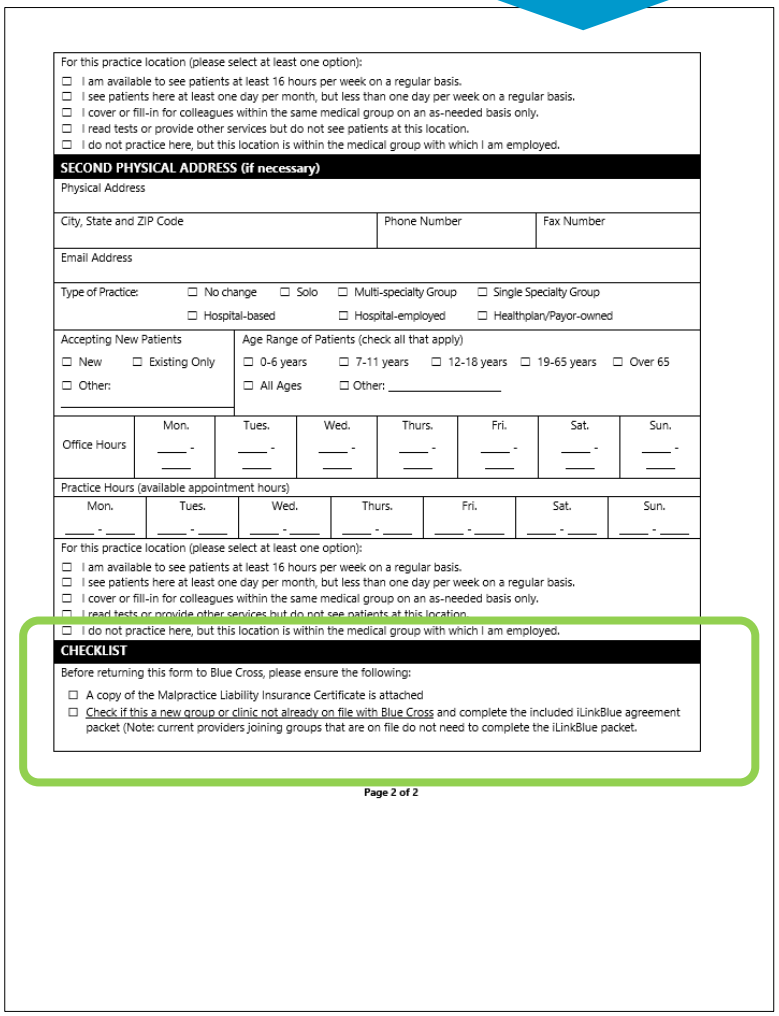
UPDATING YOUR INFORMATION

It is important that we always have your most current information!

Some change selections on the **Provider Update Request Form** include a checklist of required supporting documentation needed to complete your request.

- Complete the checklist:
- 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

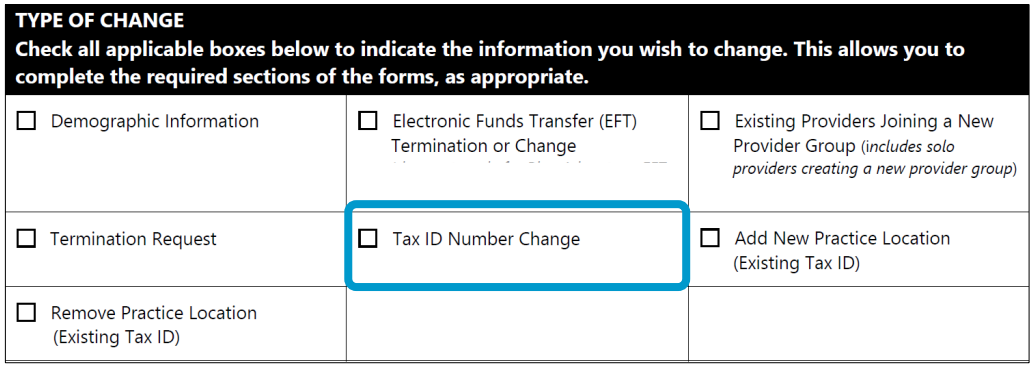
Before returning this form to Blue Cross, please ensure the following:

☐ 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

UPDATING YOUR INFORMATION

When requesting a **Tax ID Number Change**, it may be required that the provider undergo the credentialing process again.



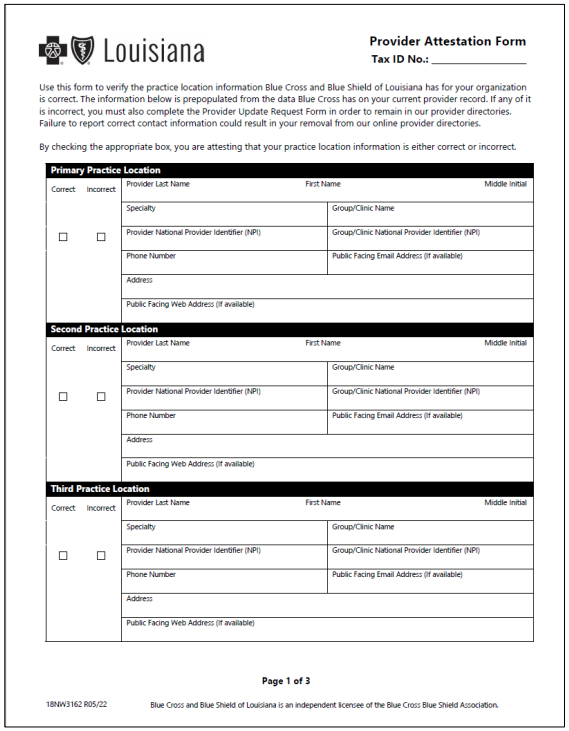
TYPE OF CHANGE
Check all applicable boxes below to indicate the information you wish to change. This allows you to complete the required sections of the forms, as appropriate.

☐ Demographic Information	☐ Electronic Funds Transfer (EFT) Termination or Change	☐ 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)		

- Most **professional providers** are already credentialed and simply changing Tax ID number does not require credentialing.
- **Facilities** changing Tax ID number must be credentialed under the new number
- Credentialing is required for **delegated providers** changing to a non-delegated group when they are not already credentialed through another non-delegated group.
- New contracting is required when changing to a Tax ID number that is not already set up in our system.

ATTESTING TO YOUR DIRECTORY INFORMATION

Provider Attestation Form



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)		

Page 1 of 3

18NW3162 R05/22 Blue Cross and Blue Shield of Louisiana is an independent licensee of the Blue Cross Blue Shield Association.

Our PCDM Department sends either a **prefilled Provider Attestation Form** via DocuSign® (or a spreadsheet to larger groups) every 90 days to providers listed in our online provider directories. These providers are **required to review** their information.

✓

If the information is correct, then electronically give attestation, sign and return the form.

X

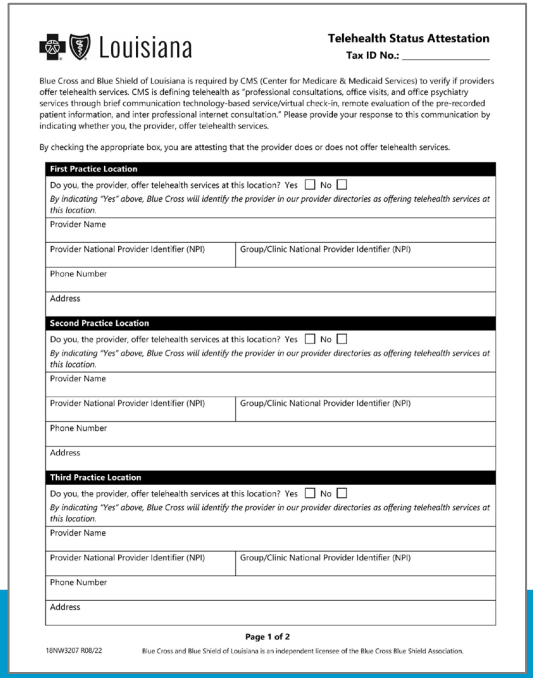
If any of the information is incorrect, please complete the Provider Update Request Form (a link is included in the attestation form). This allows us to update the information we publish in our directories.

Failure to complete this attestation of information will result in provider being removed from our online provider directories.

ATTESTATION OF TELEHEALTH SERVICES

Telehealth Attestation Form

- The Centers for Medicare & Medicaid Services (CMS) requires Blue Cross to verify if providers offer telehealth services.
- The Telehealth Status Attestation form will be sent by email to the Provider through DocuSign.
- Please do not decline the Telehealth Status Attestation form.
- If a "Yes" response is indicated for a location on the Telehealth Attestation form, BCBSLA will identify the provider in our provider directories as offering telehealth services at that location.



Louisiana

Telehealth Status Attestation
Tax ID No.: _____

Blue Cross and Blue Shield of Louisiana is required by CMS (Center for Medicare & Medicaid Services) to verify if providers offer telehealth services. CMS is defining telehealth as "professional consultations, office visits, and office psychiatry services through brief communication technology-based service/virtual check-in, remote evaluation of the pre-recorded patient information, and inter professional internet consultation." Please provide your response to this communication by indicating whether you, the provider, offer telehealth services.

By checking the appropriate box, you are attesting that the provider does or does not offer telehealth services.

First Practice Location

Do you, the provider, offer telehealth services at this location? Yes ☐ No ☐

By indicating "Yes" above, Blue Cross will identify the provider in our provider directories as offering telehealth services at this location.

Provider Name

Provider National Provider Identifier (NPI) | Group/Clinic National Provider Identifier (NPI)

Phone Number

Address

Second Practice Location

Do you, the provider, offer telehealth services at this location? Yes ☐ No ☐

By indicating "Yes" above, Blue Cross will identify the provider in our provider directories as offering telehealth services at this location.

Provider Name

Provider National Provider Identifier (NPI) | Group/Clinic National Provider Identifier (NPI)

Phone Number

Address

Third Practice Location

Do you, the provider, offer telehealth services at this location? Yes ☐ No ☐

By indicating "Yes" above, Blue Cross will identify the provider in our provider directories as offering telehealth services at this location.

Provider Name

Provider National Provider Identifier (NPI) | Group/Clinic National Provider Identifier (NPI)

Phone Number

Address

Page 1 of 2

18NW3207 R08/22 Blue Cross and Blue Shield of Louisiana is an independent licensee of the Blue Cross Blue Shield Association.

CMS defines telehealth as "professional consultations, office visits, and office psychiatry services through brief communication technology-based service/virtual check-in, remote evaluation of the pre-recorded patient information, and inter-professional internet consultation."

Supporting Our Providers

THE PCDM DEPARTMENT

Provider Network Setup, Credentialing, Contracting & Demographic Changes

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

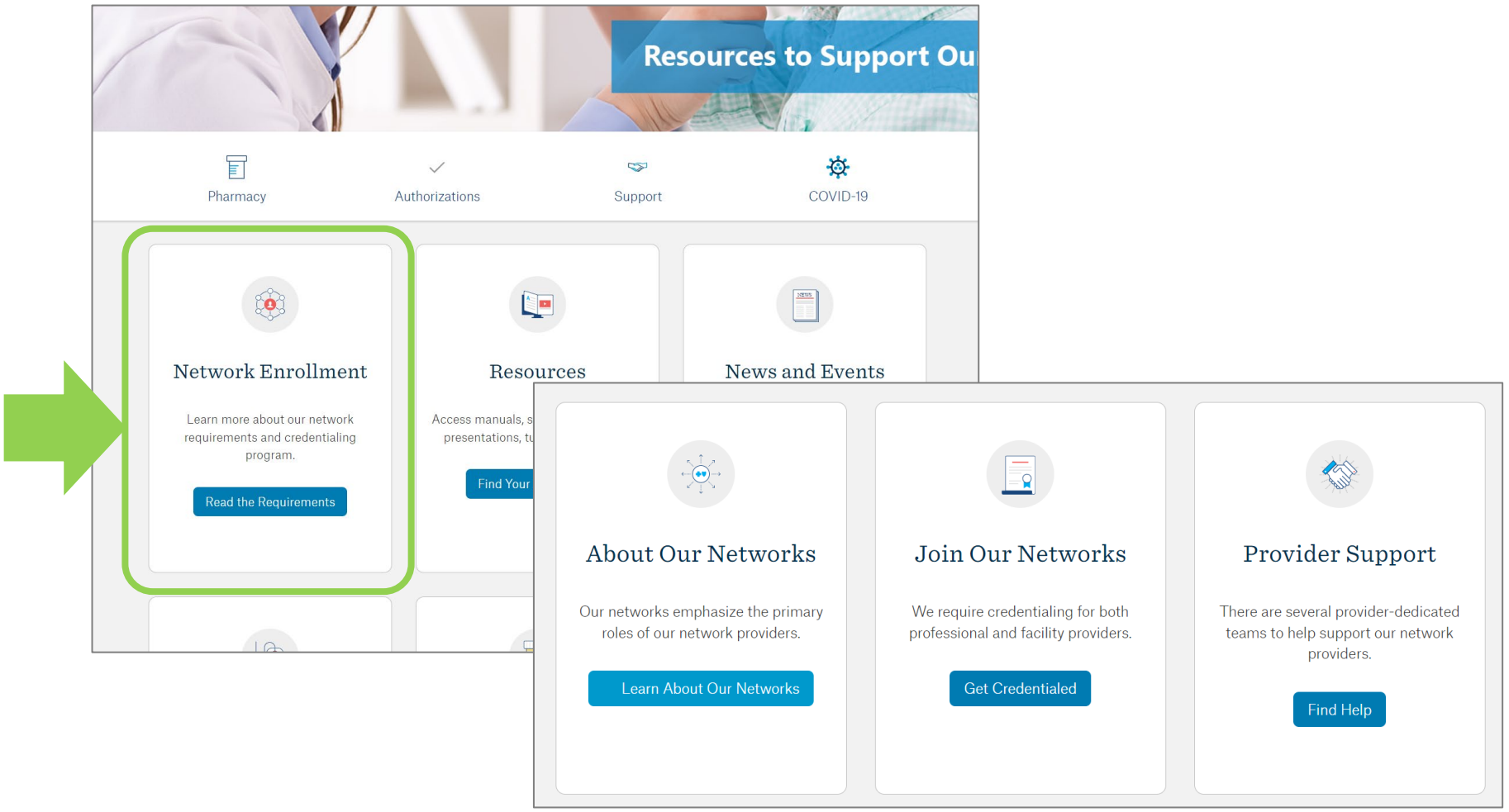
Kaci Guidry
manager, Provider Credentialing & Data Management
kaci.guidry@bcbsla.com

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

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

To check the status on your credentialing application or provider data update, please email **PCDMstatus@bcbsla.com** or call 1-800-716-2299, option 2.

THE PROVIDER PAGE www.bcbsla.com/providers

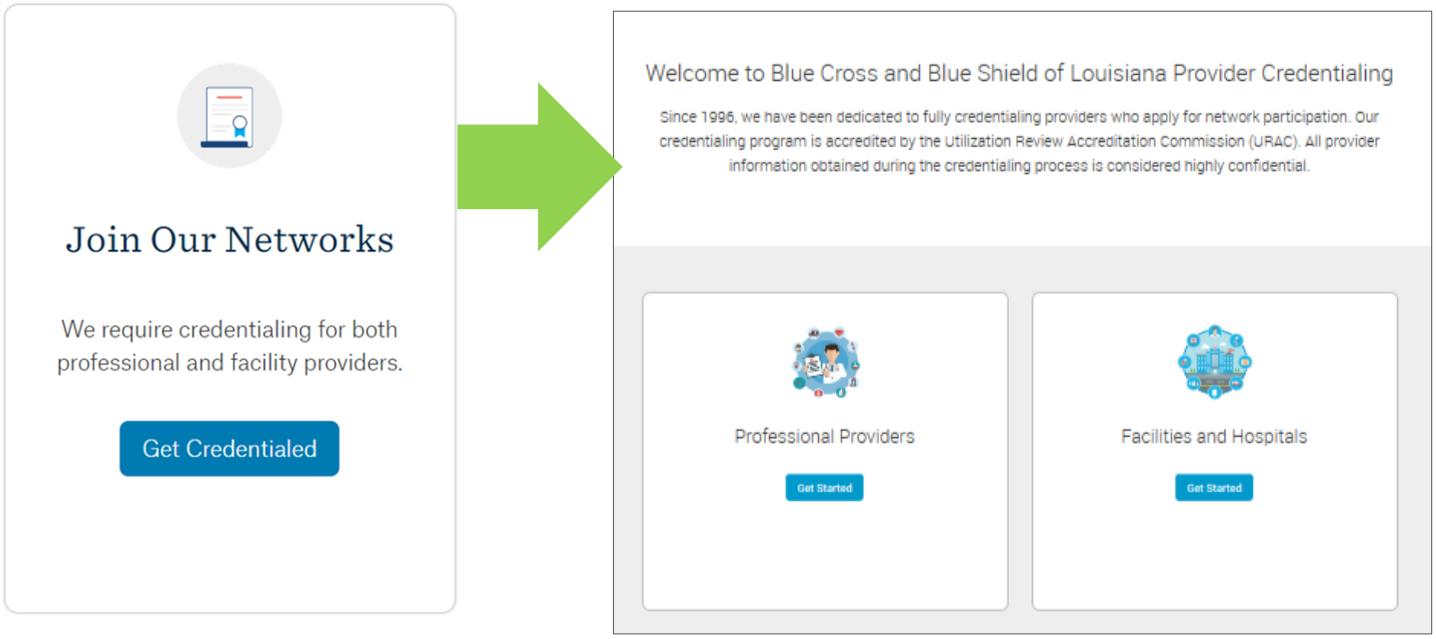


Choose **Network Enrollment** to view more information about our networks.

THE NETWORK ENROLLMENT PAGE

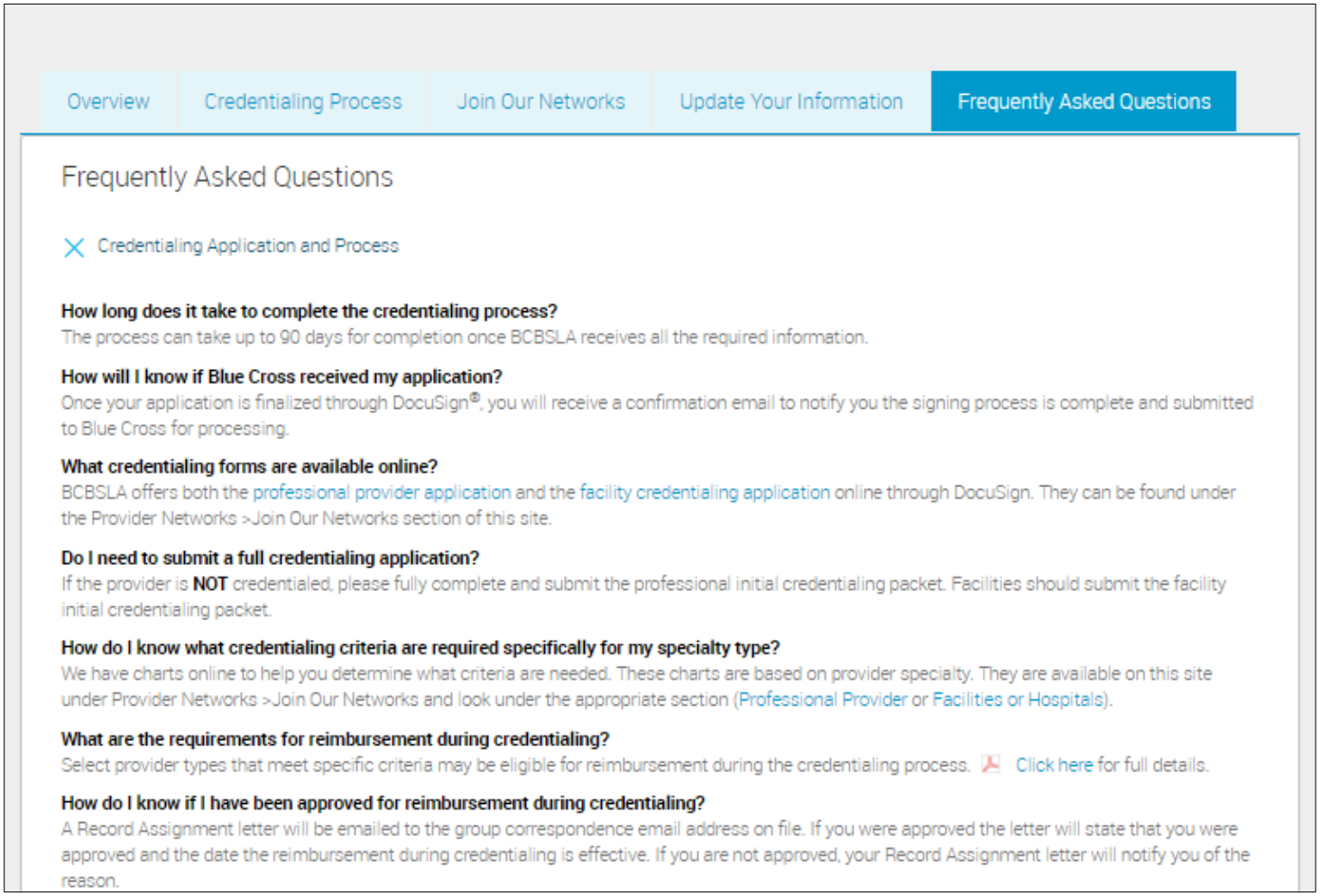
You **MUST** complete and submit documentation to start the process for credentialing **OR** to obtain a provider record.

Applications are available online at **www.bcbsla.com/providers**.



Choose **Network Enrollment**, then **Join Our Networks** page then, select **Professional Providers** or **Facilities and Hospitals** to find credentialing packets.

CREDENTIALING FAQs



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

QUESTION TIME!

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

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

More Good Information

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®

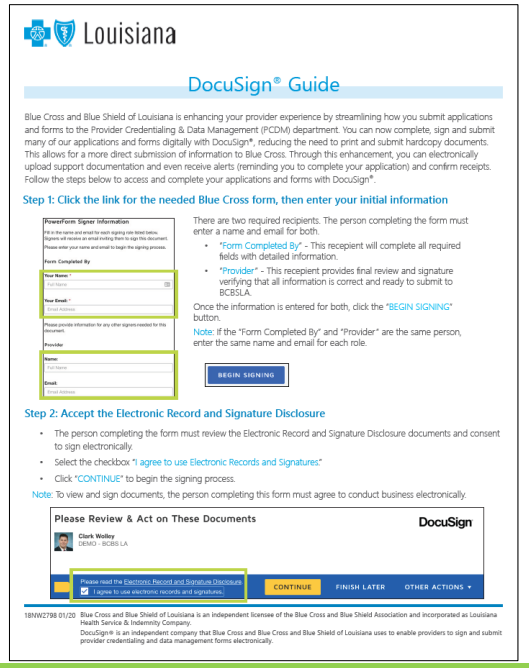
Complete, sign and submit applications and forms to the PCDM Department digitally with **DocuSign®**.

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

Clark Walley
DEMO - BCBS LA

Please read the Electronic Record and Signature Disclosure
I agree to use electronic records and signatures.

CONTINUE FINISH LATER OTHER ACTIONS

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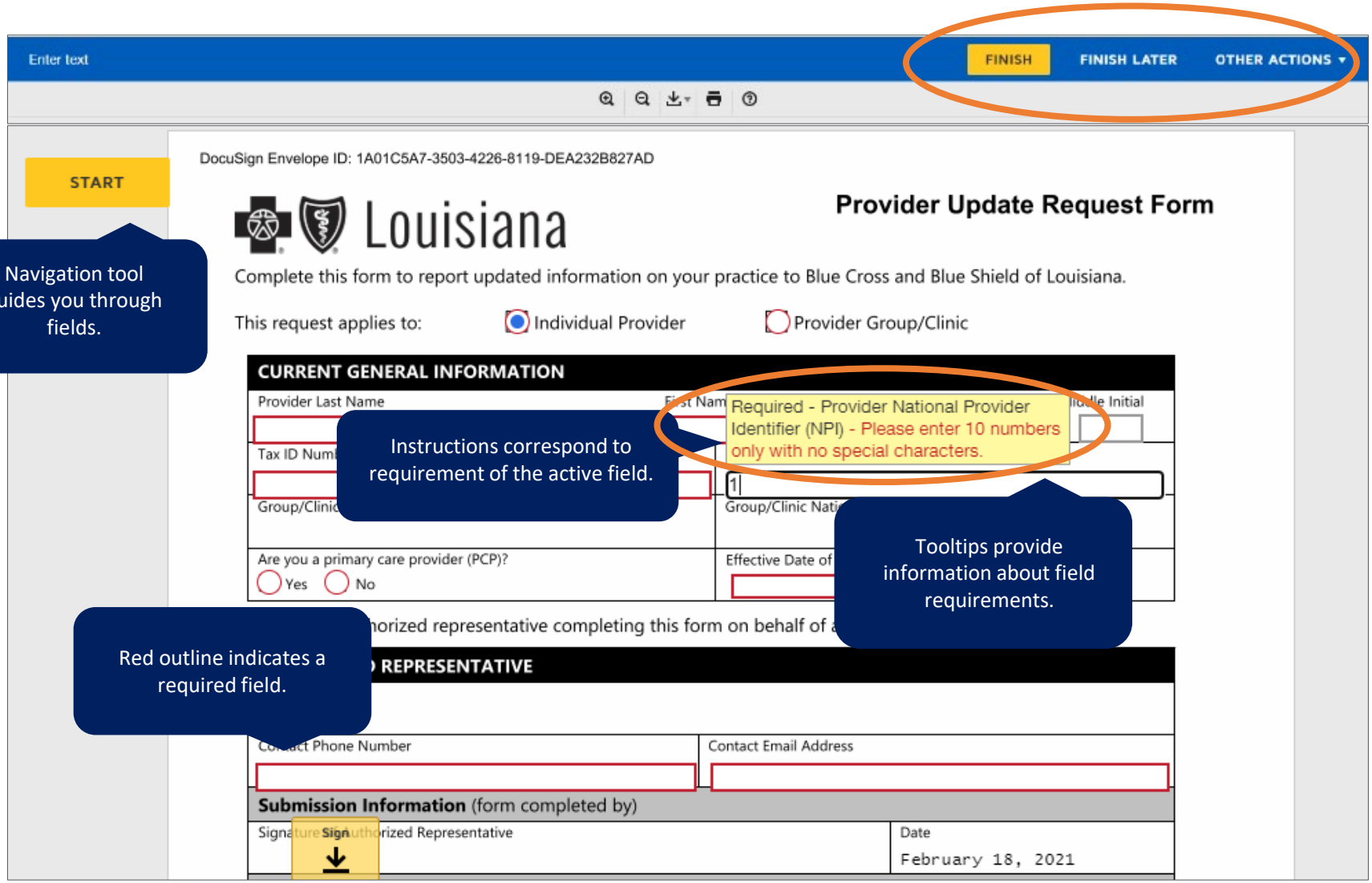
DocuSign® is an independent company that Blue Cross and Blue Cross and Blue Shield of Louisiana uses to enable providers to sign and submit provider credentialing and data management forms electronically.

View our *DocuSign® Guide* online at **www.bcbsla.com/providers** >Network Enrollment >Join Our Networks >Professional Providers/Facilities and Hospitals >Join Our Networks.

Easily Complete Forms with DocuSign®



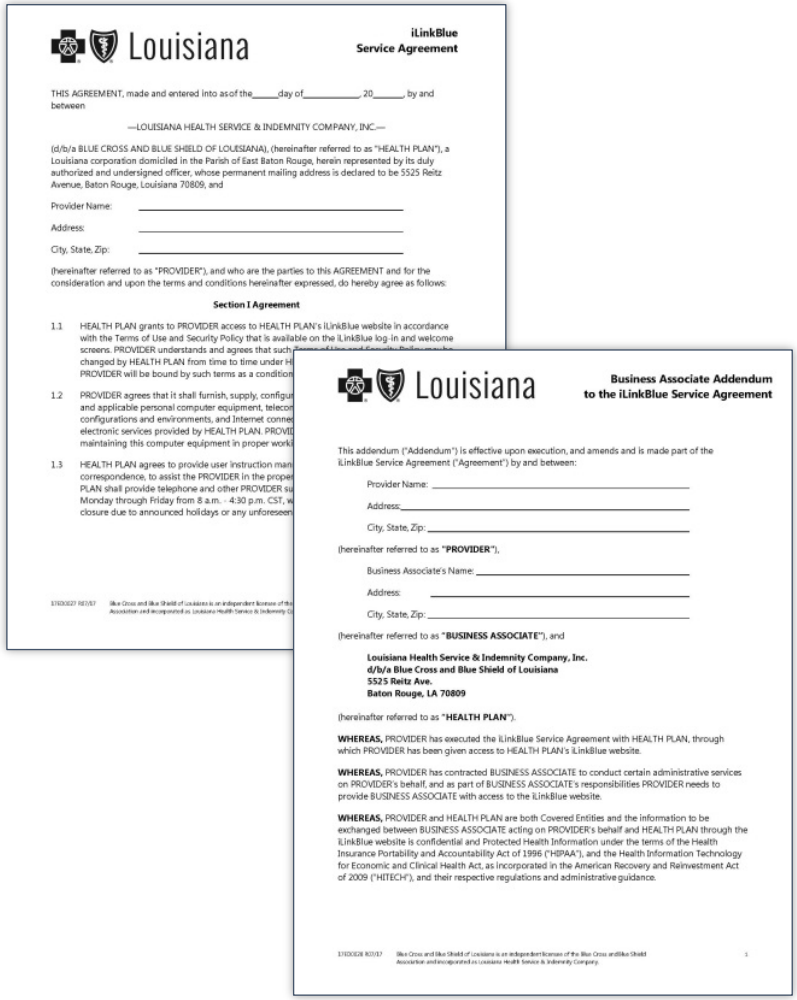
iLinkBlue Application

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.

- 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

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
changed by HEALTH PLAN from time to time under H
PROVIDER will be bound by such terms as a condition

1.2 PROVIDER agrees that it shall furnish, supply, configu
and applicable personal computer equipment, telecon
configurations and environments, and Internet conne
electronic services provided by HEALTH PLAN. PROVI
maintaining this computer equipment in proper worki

1.3 HEALTH PLAN agrees to provide user instruction man
correspondence, to assist the PROVIDER in the proper
PLAN shall provide telephone and other PROVIDER su
Monday through Friday from 8 a.m. - 4:30 p.m. CST, w
closure due to announced holidays or any unforeseen

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

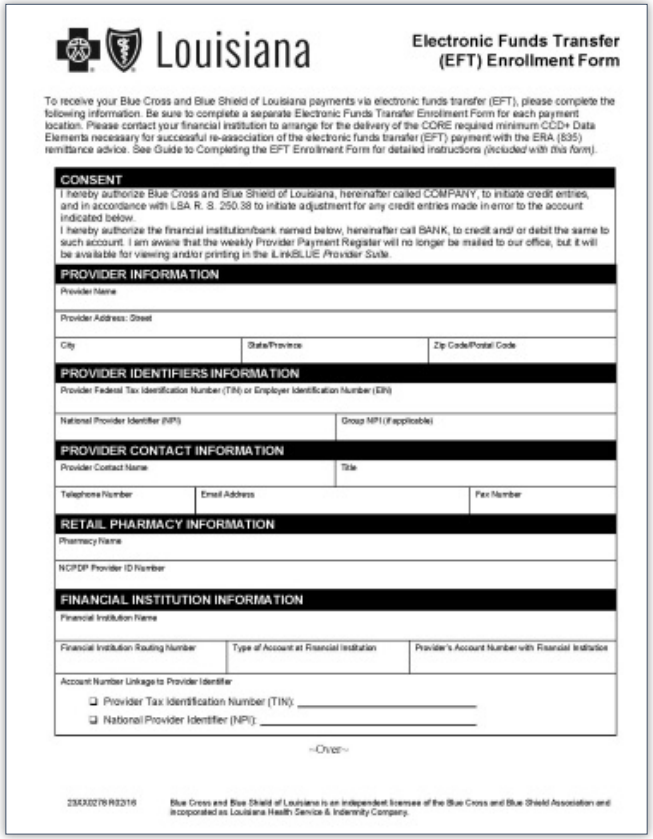
(hereinafter referred to as **"HEALTH PLAN"**).

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.

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~

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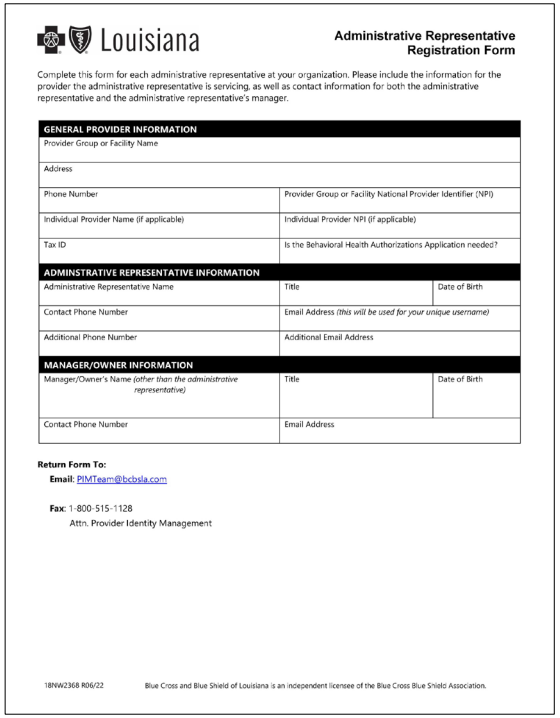
- EFT is a free provider service where Blue Cross deposits your payment directly into your checking account.
- With iLinkBlue, you have access to EFT notifications and Payment Registers/ Remittance Advices (can be printed directly).
- All Blue Cross providers **must** be part of our EFT program, including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

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

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