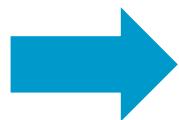


Provider Credentialing & Data Management Webinar

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.



CREDENTIALING, CONTRACTING, RECREDENTIALING & DATA MANAGEMENT

February 2024



Presented by:
Melonie Martin
provider relations representative

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

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 **symplrCVO** to conduct credentialing verification processes for our commercial and Blue adVantage networks.

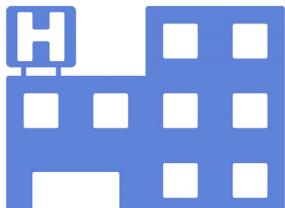
THE BASICS

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)*



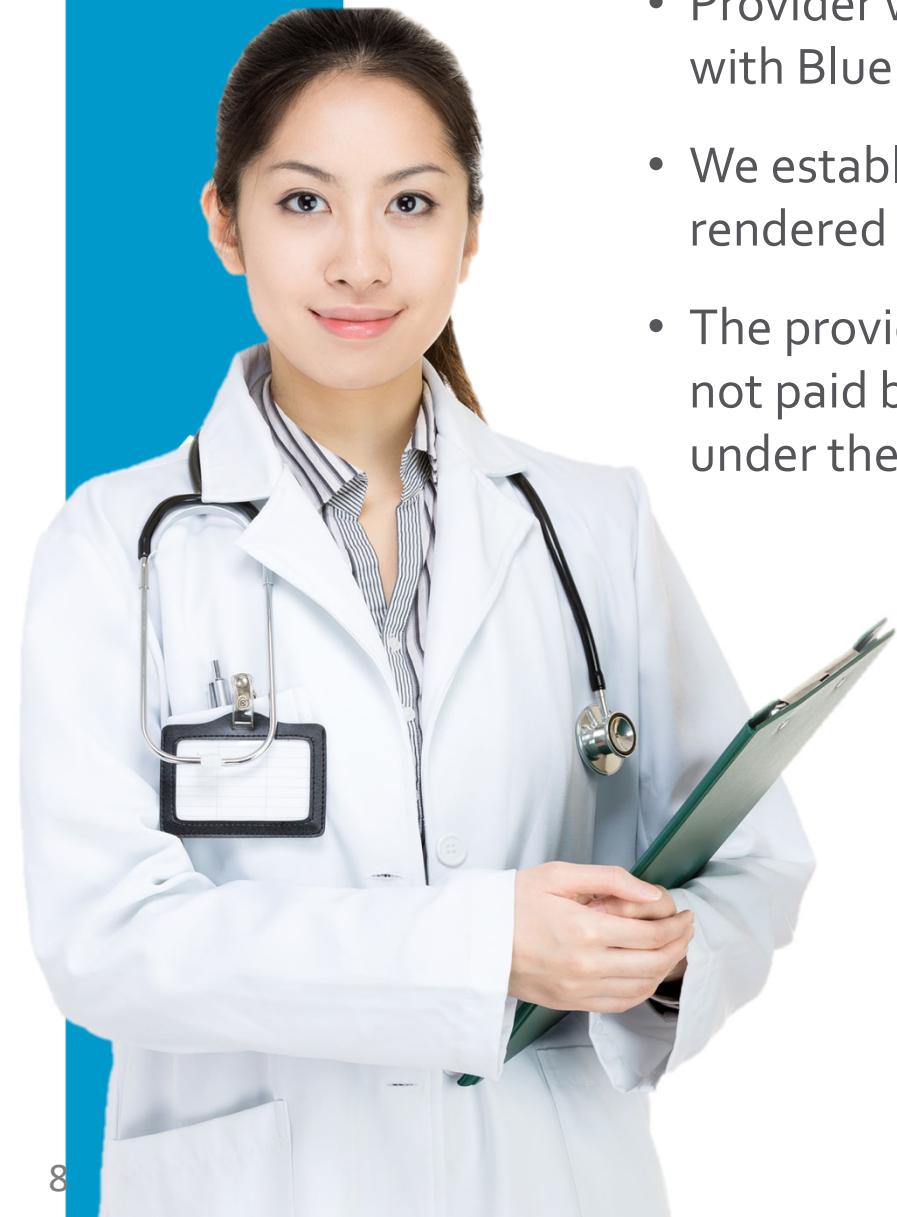
No Contract
&
Provider **IS NOT**
credentialed

What is a Participating Provider?

- Provider who 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 who 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

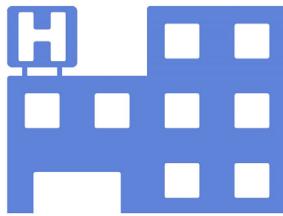


Professional Provider Network Availability

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.

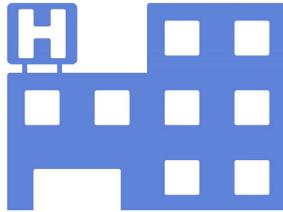


Facility Network Availability

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 (including CMS Independent Diagnostic Testing Facilities)
- 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/facility-based provider includes:

- Providers who **only** see patients as a result of their being admitted or directed to the hospital.
- Providers who **only** read test results or perform services in a facility, for which a member cannot directly make an appointment.
- Medical staff.

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

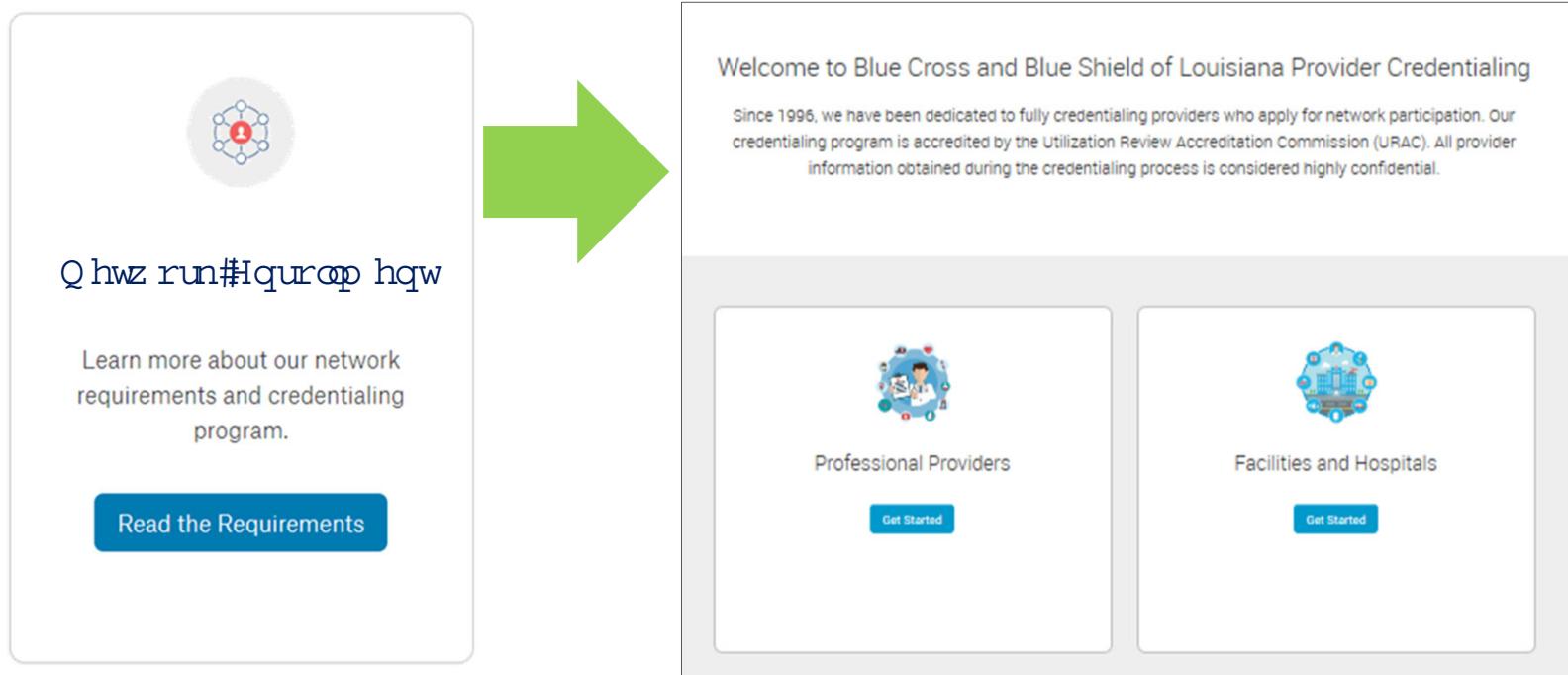
Our credentialing policy includes guidance for the provision of telehealth services to our members **WHEN**:

- **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.
 - Behavioral health telehealth-only providers are not required to 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 the providers physical location 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	
<p>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. <u>All required documents must be fully completed with a signature and date.</u> 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.</p>	
<input type="checkbox"/> I wish to PARTICIPATE in Blue Cross' network(s)	<input type="checkbox"/> I wish to obtain a Blue Cross record only as a NON-PARTICIPATING provider
<input type="checkbox"/> New Contract <i>Our Provider Contract Department will contact you regarding a new network agreement.</i>	<input type="checkbox"/> Joining an Existing Group <i>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.</i>
<input type="checkbox"/> Complete the Louisiana Standardized Credentialing Application <ul style="list-style-type: none"><input type="checkbox"/> Attachment A - Location Hours<input type="checkbox"/> Complete the iLinkBlue Service Agreement<input type="checkbox"/> Complete the Business Associate Addendum to the iLinkBlue Service Agreement<input type="checkbox"/> Complete the Electronic Funds Transfer (EFT) Enrollment Form<input type="checkbox"/> Enclose a canceled check/bank letter confirming account<input type="checkbox"/> Complete the Administrative Representative Registration Form<input type="checkbox"/> Complete the Administrative Representative Acknowledgment Form<input type="checkbox"/> Enclose an EIN Letter<input type="checkbox"/> Enclose a W-9 Form<input type="checkbox"/> Enclose a copy of state license<input type="checkbox"/> Enclose a copy of DEA registration and CDS license <i>(as applicable)</i><input type="checkbox"/> Enclose a copy of Malpractice Liability Certificate <i>(copy of policy declarations page)</i><input type="checkbox"/> Enclose a copy of the Collaborating Physician Agreement/Supervising Physician Agreement (NP/PA). Collaborating physician must participate in the same network as the applicant.<input type="checkbox"/> Enclose a copy of Malpractice Liability Certificate <i>(copy of policy declarations page)</i>	<input type="checkbox"/> Complete the Louisiana Standardized Credentialing Application <ul style="list-style-type: none"><input type="checkbox"/> Attachment A - Location Hours<input type="checkbox"/> Enclose a copy of state license<input type="checkbox"/> Enclose a copy of DEA/CDS Licenses <i>(where applicable)</i><input type="checkbox"/> Enclose a copy of Malpractice Liability Certificate <i>(copy of policy declarations page)</i><input type="checkbox"/> Enclose a copy of the Collaborating Physician Agreement/Supervising Physician Agreement (NP/PA). Collaborating physician must participate in the same network as the applicant.

- 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.

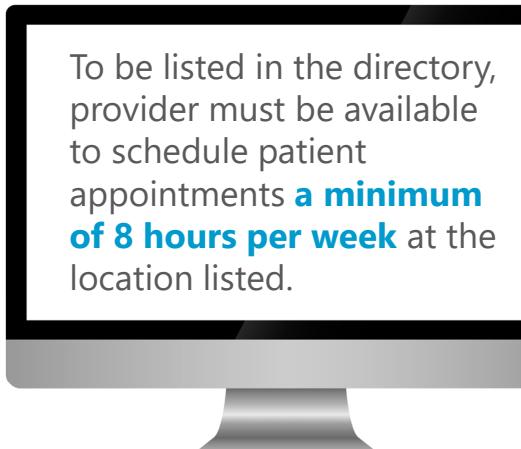
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DIRECTIONS Please type or print in black ink when completing this form. If you need more space or have more than four locations, attach additional sheets and reference the question being answered. Please see page 10 for a list of required documents. ** All sections must be completed in their entirety. "See C.V.", not acceptable**																																																																																																																																											
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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 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 <table border="1"> <tr> <td colspan="2">Individual Provider Last Name</td> <td colspan="2">First Name</td> <td colspan="5">Middle Initial</td> </tr> <tr> <td colspan="2">Individual Provider NPI</td> <td colspan="7">Group/Clinic Tax ID Number</td> </tr> </table>									Individual Provider Last Name		First Name		Middle Initial					Individual Provider NPI		Group/Clinic Tax ID Number																																										
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FOR THE PRIMARY PRACTICE LOCATION REPORTED ON THE CREDENTIALING APPLICATION <table border="1"> <tr> <td colspan="2">Group NPI</td> <td colspan="7">This form is for professional providers only.</td> </tr> <tr> <td colspan="9"> Do you, the provider, offer telehealth services? <input type="checkbox"/> Yes <input type="checkbox"/> No By indicating "Yes," Blue Cross will identify the provider in our provider directory as offering telehealth services at this location. </td> </tr> <tr> <td colspan="9"> Practice Hours Available/Not Available <table border="1"> <tr> <td>Mon.</td> <td>Tue.</td> <td>Wed.</td> <td>Thu.</td> <td>Fri.</td> <td>Sat.</td> <td>Sun.</td> </tr> </table> </td> </tr> <tr> <td colspan="9"> <small>For this practice location, please indicate at least one option:</small> <ul style="list-style-type: none"> <input type="checkbox"/> I am available to see patients at least 8 hours per week on a regular basis. <input type="checkbox"/> I see patients here at least one day per month, but less than one day per week on a regular basis. <input type="checkbox"/> I cover or fill in for colleagues within the same medical group on an as-needed basis only. <input type="checkbox"/> I read tests or provide other services but do not see patients at this location. <input type="checkbox"/> I do not practice here, but this location is within the medical group with which I am employed. </td> </tr> </table>									Group NPI		This form is for professional providers only.							Do you, the provider, offer telehealth services? <input type="checkbox"/> Yes <input type="checkbox"/> No By indicating "Yes," Blue Cross will identify the provider in our provider directory as offering telehealth services at this location.									Practice Hours Available/Not Available <table border="1"> <tr> <td>Mon.</td> <td>Tue.</td> <td>Wed.</td> <td>Thu.</td> <td>Fri.</td> <td>Sat.</td> <td>Sun.</td> </tr> </table>									Mon.	Tue.	Wed.	Thu.	Fri.	Sat.	Sun.	<small>For this practice location, please indicate at least one option:</small> <ul style="list-style-type: none"> <input type="checkbox"/> I am available to see patients at least 8 hours per week on a regular basis. <input type="checkbox"/> I see patients here at least one day per month, but less than one day per week on a regular basis. <input type="checkbox"/> I cover or fill in for colleagues within the same medical group on an as-needed basis only. <input type="checkbox"/> I read tests or provide other services but do not see patients at this location. <input type="checkbox"/> I do not practice here, but this location is within the medical group with which I am employed. 																			
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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 state licensed 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 hereinabove 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 website sections of the iLinkBlue website. The iLinkBlue website is the sole property of HEALTH PLAN and 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 the 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, configuration and networking, and other equipment and supplies required 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 otherwise to PROVIDER to assist in the use of the iLinkBlue website. PROVIDER agrees that HEALTH PLAN will 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.

ST00027 01/01 Blue Cross and Blue Shield of Louisiana is an independent licensee of the Blue Cross and Blue Shield Association and is not affiliated with Louisiana Health Service & Indemnity Company.

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 Associates Name: _____
Address: _____
City, State, Zip: _____
(hereinafter referred to as “BUSINESS ASSOCIATE”).

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 granted access to HEALTH PLAN’s iLinkBlue website.

WHEREAS, PROVIDER has contracted with iLinkBlue to provide iLinkBlue 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.

ST00027 01/01 Blue Cross and Blue Shield of Louisiana is an independent licensee of the Blue Cross and Blue Shield Association and is not affiliated with Louisiana Health Service & Indemnity Company.

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 enrollment. Be sure to complete a separate Electronic Funds Transfer Enrollment Form for each payment method. Please confirm that the information you provide is the same as the information on the enrollment form. Data Elements necessary for successful re-association of the electronic funds transfer (EFT) payments with the ERA (855) information. See Grade 40 for completing the EFT Enrollment Form for detailed instructions (enclosed with this form).

CONSENT

I hereby authorize Blue Cross and Blue Shield of Louisiana, herein called COMPANY, to initiate credit entries, and in accordance with L.B.R. § 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, herein called BANK, to credit and/or debit funds to my bank account indicated below. I understand that my bank account information will no longer be needed by my office, and it will not be available for viewing and/or printing in the LeadsLUE Provider Suite.

PROVIDER INFORMATION

Provider Name _____
Provider Address: _____
City _____ State _____ Zip _____
Zip Code/Postal Code _____

PROVIDER IDENTIFIERS INFORMATION

Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN) _____
Group NPI (if applicable) _____

PROVIDER CONTACT INFORMATION

Provider Contact Name _____
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 in Financial Institution _____
Provider’s Account Number with Financial Institution _____
Account Number Unique to Provider Institution _____
□ Provider Tax Identification Number (TIN) _____
□ National Provider Identifier (NPI) _____

23532027 01/01 Blue Cross and Blue Shield of Louisiana is an independent licensee of the Blue Cross and Blue Shield Association and is not affiliated with Louisiana Health Service & Indemnity Company.

Louisiana Administrative Representative Registration Form

Complete this form for each administrative representative of your organization. Please include the information for the primary administrative representative in service, 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) _____
Fax 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: ProviderIdentityManagement@bcbsla.com
Fax: 1-800-415-1128
Attn: Provider Identity Management

BCBSLA – Provider Identity Management
P.O. Box 9829
Baton Rouge, LA 70806-9829

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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

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.

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



Credentialing Checklist for Facilities

All required documents must be fully completed with a handwritten signature and date (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.

There are two options below for obtaining a Blue Cross provider record. You may choose to participate in our networks or simply obtain a provider record as a non-participating provider for the purpose of filing claims. Use the appropriate checklist below to fully complete this credentialing packet. See [Facility Providers Credentialing Criteria](#) for more information.

Choose One (non-participating provider checklist on back)

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

New Contract
Our Network Development department will contact you regarding a new network agreement.

Complete the Health Delivery Organization (HDO) Information Form

Complete the Health Delivery Organization Statement of Attestation

Complete the applicable HDO Attachment

HDO Attachment A: Ambulance Company

HDO Attachment B: DME Supplier or Pharmacy

HDO Attachment C: Hospital, Ambulatory Surgical Center or Free-standing Skilled Nursing Facility

Complete the **Patient Safety Regulation Statement of Attestation (if applicable)**

HDO Attachment D: Urgent Care Clinic / Walk-in Clinic

HDO Attachment E: Diagnostic Radiology (Free-standing)

HDO Attachment F: Retail Health

HDO Attachment G: Laboratory

HDO Attachment H: Outpatient Cath Lab

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 Malpractice Liability Certificate (copy of policy declarations page)

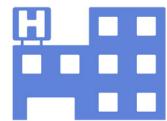
Enclose this completed checklist

Submit all required documents using one of the options below:

mail: BCBSLA - PCDM
P.O. Box 98029
Baton Rouge, LA 70898-9029

email: network.administration@bcbsla.com
fax: (225) 297-2750
Attention: PCDM

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



THE PAPERWORK for facilities

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

FIRST PRACTICE LOCATION									
Name of Facility									
Physical Address		State	ZIP Code						
City		State	ZIP Code						
Parish/County		Physical Address Email							
Main Phone Number	Appointment Phone Number	Fax Number	Tax Identification Number						
Facility Contact		NPI Number							
Office Hours	Mon.	Tues.	Wed.	Thurs.	Fri.	Sat.	Sun.		
Billing Address (where you want payments sent)									
City		State	ZIP Code						
Billing Address Email		Phone Number	Fax Number						
Correspondence Address (where you want communications sent)		Billing Contact Person							
City		State	ZIP Code						
Correspondence Address Email		Phone Number	Fax Number						
Correspondence Contact Person		Correspondence Contact Person							
Medical Records Address (where you want medical record requests sent)									
City		State	ZIP Code						
Medical Records Email		Phone Number	Fax Number						
Medical Records Contact Person		Medical Records Contact Person							
Does the office offer handicapped access for:		Building	<input type="checkbox"/> Yes <input type="checkbox"/> No	Parking	<input type="checkbox"/> Yes <input type="checkbox"/> No	Restroom	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other	<input type="checkbox"/>
Accessible by public transportation:		Bus	<input type="checkbox"/> Yes <input type="checkbox"/> No	Car/Service	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other	<input type="checkbox"/>		
Offers services for the disabled:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Text Telephony (TTY)	<input type="checkbox"/> Yes <input type="checkbox"/> No	American Sign Language	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mental/Physical Impairment Services	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other	<input type="checkbox"/>
Does the office meet the American With Disabilities Accessibility (ADA) requirements?									
<input type="checkbox"/> Yes <input type="checkbox"/> No									
Patient Ages: Please check the age ranges of the client populations you treat:									
<input type="checkbox"/> 0 to 6 <input type="checkbox"/> 7 to 11 <input type="checkbox"/> 12 to 18 <input type="checkbox"/> 19 to 65 <input type="checkbox"/> Over 65 <input type="checkbox"/> All Ages									
<input type="checkbox"/> Other (please specify):									

1 of 6
23XX6077 R03/18
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.

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 <i>Health Service & Indemnity Company</i>	lklBlue Service Agreement
<p>THIS AGREEMENT, made and entered into as of the <u> day of </u>, 20<u> </u>, by and between:</p> <p style="text-align: center;">—LOUISIANA HEALTH SERVICE & INDEMNITY COMPANY, INC.—</p> <p>(lklBlue CROSS AND BLUE SHIELD OF LOUISIANA, hereinafter referred to as "HEALTH PLAN"), a Louisiana corporation, with its principal office at East Baton Rouge, herein represented by its duly authorized and undersigned officer, whose permanent mailing address is declared to be 5325 Heitz Avenue, Baton Rouge, Louisiana 70809, and</p>	
<p>Provider Name: _____ Address: _____ City, State, Zip: _____</p>	
<p>Provider is referred to as "PROVIDER" and lklBlue are the parties to this AGREEMENT and for the consideration and upon the terms and conditions hereinafter expressed, do hereby agree as follows:</p>	
<p>Section 1 Agreement</p>	
<p>1.1 HEALTH PLAN grants to PROVIDER and lklBlue the right to use lklBlue website in accordance with the Terms of Use and Security Policy that is available on the lklBlue log in and welcome screen. PROVIDER understands and agrees that such Terms of Use and Security Policy may be changed by HEALTH PLAN from time to time and HEALTH PLAN's sole discretion, and that PROVIDER shall be bound by such changes.</p>	
<p>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 claims processing system of lklBlue. PROVIDER further agrees that it is responsible for maintaining the computer equipment in proper working condition.</p>	
<p>1.3 HEALTH PLAN agrees to provide user instruction manuals and documentation or correspondence, to assist the PROVIDER in the proper use of the lklBlue website. HEALTH PLAN shall provide telephone and other PROVIDER support services it deems reasonable Monday through Friday from 8 a.m. to 4:30 p.m. CST, with the exception of HEALTH PLAN office closure due to announced holidays or any unforeseen circumstances.</p>	

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. You will be required to complete a separate EFT Enrollment Form for each payment method. Please attach a copy of the enrollment form to the reverse side of this form for the return of the EFT Enrollment Form. Elements necessary for successful re-association of the electronic funds transfer (EFT) payments with the ERA (E81) elements are included. Please complete the EFT Enrollment Form for detailed instructions (including with the form).

CONSENT

I hereby authorize Blue Cross and Blue Shield of Louisiana, hereinafter called COMPANY, to initiate credit entries, and initiate debits from my account with LRA # S-250 880 to inflate adjustment for any credit entries made in error to the account indicated below.

I hereby authorize the COMPANY to contact my financial institution, my bank, to credit and/or debit the sum to be inflated to my account, and to provide the weekly Payroll Payment Register so long as it is no longer mailed to my office, but it will be available for viewing and/or printing in the Lexis/LSC/PowerState.

PROVIDER INFORMATION

Provider Name

Provider Address: Street

City

State/Province

Zip/Postal Code

PROVIDER IDENTIFIERS INFORMATION

Provider Federal Tax Identifier Number (TIN) or Unique Identification Number (UI#)

National Provider Identifier (NPI)

Group NPI/GroupNPI

PROVIDER CONTACT INFORMATION

Provider Contact Name

Title

Telephone Number

E-mail Address

Fax Number

RETAIL PHARMACY INFORMATION

Pharmacy Name

NCPDP Provider ID Number

FINANCIAL INSTITUTION INFORMATION

Financial Institution Name

Financial Institution Number	Type of Account at Financial Institution	Provider's Account Number with Financial Institution
------------------------------	--	--

Account Number Unique to Provider Name

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

-Over-

20040279 RE2016

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

	Louisiana	Administrative Representative Registration Form												
<p>Complete this form for each administrative representative at your organization. Please include the information for the provider the administrative representative is serving as well as contact information for both the administrative representative and the administrative representative's manager.</p>														
GENERAL PROVIDER INFORMATION														
<table border="0"> <tr> <td>Practice or Facility Name</td> <td colspan="2"></td> </tr> <tr> <td colspan="3">Address</td> </tr> <tr> <td>Phone Number:</td> <td colspan="2">National Provider Identifier (NPI)</td> </tr> <tr> <td colspan="3">Fax ID</td> </tr> </table>			Practice or Facility Name			Address			Phone Number:	National Provider Identifier (NPI)		Fax ID		
Practice or Facility Name														
Address														
Phone Number:	National Provider Identifier (NPI)													
Fax ID														
ADMINISTRATIVE REPRESENTATIVE INFORMATION														
<table border="0"> <tr> <td>Administrative Representative Name</td> <td>Title</td> <td>Date of Birth</td> </tr> <tr> <td colspan="3">Contact Phone Number:</td> </tr> <tr> <td colspan="3">Email Address</td> </tr> </table>			Administrative Representative Name	Title	Date of Birth	Contact Phone Number:			Email Address					
Administrative Representative Name	Title	Date of Birth												
Contact Phone Number:														
Email Address														
MANAGEMENT INFORMATION														
<table border="0"> <tr> <td>Manager Name (the name of the administrative representative is the office manager)</td> <td>Title</td> <td>Date of Birth</td> </tr> <tr> <td colspan="3">Contact Phone Number</td> </tr> <tr> <td colspan="3">Email Address</td> </tr> </table>			Manager Name (the name of the administrative representative is the office manager)	Title	Date of Birth	Contact Phone Number			Email Address					
Manager Name (the name of the administrative representative is the office manager)	Title	Date of Birth												
Contact Phone Number														
Email Address														
<p>Return Form To: Email: ProviderAdmin@dhss.louisiana.gov</p> <p>Fax: 1-800-515-1128</p> <p>Attn: Provider Identity Management</p>														
<p>Mail: BCBSLA - Provider Identity Management P.O. Box 98029 Baton Rouge, LA 70808-9292</p>														

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 Credentialled

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 an email to PCDMstatus@bcbsla.com.



VERIFYING YOUR INFORMATION



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

Professional providers in the credentialing and recredentialing process may be directly contacted by symplrCVO to verify application details and supporting documentation. This does not apply to facilities.



symplrCVO will 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.



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

Expedited processing applies to a limited group of professional providers only. In most cases, this applies to practitioners with admitting privileges or admitting arrangements.

Louisiana law allows professional providers a 30-day expedited application processing. To be eligible for expedited processing, providers must meet the following criteria:

- Providers who are:
 - Already credentialed with Blue Cross and are joining a new group, or
 - Are not yet credentialed but are joining a provider group that already has an executed group agreement on file with Blue Cross for the same provider type.
- Physicians must have admitting privileges to a network hospital or an approved exception.
- When applicable, provider must list their admitting privileges information in the hospital affiliations section on the appropriate credentialing application.
- Blue Cross credentialing policy allows certain eligible providers to have an arrangement with a hospitalist group to admit their patients in lieu of their own hospital privileges. A copy of the arrangement must be submitted with the credentialing application.
- Agree to hold our members harmless for payments above the allowable amount.



Example: An NP applying for network participation must be joining a provider group that already has an executed allied health agreement on file with Blue Cross.

EXAMPLE LETTER TO BLUE CROSS

To request expedited processing, include the following with the initial credentialing application:

- Letter asking Blue Cross to invoke the expedited process.
- The letter must:
 1. Include your agreement to hold our members harmless for payments above the allowable amount.
 2. Identify the provider group name.
 3. Be on company letterhead and signed by the provider or an authorized representative. An electronic signature is acceptable.
- When applicable, signed admitting privileges agreement to a network hospital.

Sample Letter

{Date}

Dear Blue Cross and Blue Shield of Louisiana:

In accordance with the Louisiana law extending certain requirements for credentialing of healthcare providers, please accept this written request for expedited processing for *{provider's name}* 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.	<p>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</p> <p>OR</p> <p>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.</p>	<p>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.</p> <p>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.</p>

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.

Example 2: a physician joins a participating allied group (only has an allied agreement on file). The group must sign a physician agreement.

- Existing network providers asking to join a different network
- **Some** participating providers, groups or facilities changing Tax ID number (TIN).
This is outlined on Slide 47.

THE NETWORK AGREEMENT the final paperwork



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

A 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

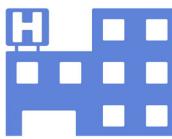
Network providers must be approved through our **recredentialing** process **every three years** (or within 1 year in some cases) from the last credentialing acceptance date. Blue Cross is partnered with symplrCVO to recredential our network providers. Blue Cross sends* recredentialing applications to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

The Credentialing Committee reviews all recredentialing applications.

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.

RECREDENTIALING



professional

Providers due for recredentialing are sent an email (provider email on file) six months prior to recredentialing due date.

The email provides:

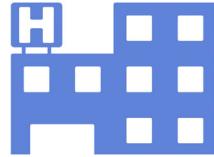
- A link to the LSCA, if using CAQH you can provide your CAQH ID
- A checklist of required supporting documentation
- Instructions on how to complete and return the application

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.

The following forms for recredentialing are accepted.

	LOUISIANA STANDARDIZED CREDENTIALING APPLICATION						
DIRECTIONS							
<p>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.</p> <p>** All sections must be completed in this entire section. C.V., not acceptable!**</p>							
GENERAL INFORMATION							
Last Name	Suffix	First	Middle	Gender	Male	Female	
Degree	<input type="checkbox"/> MD	<input type="checkbox"/> DO	<input type="checkbox"/> DPM	<input type="checkbox"/> DC	<input type="checkbox"/> DDS	<input type="checkbox"/> DMD	<input type="checkbox"/> 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							

RECREDENTIALING



facility

Facilities due for recredentialing are sent an email (provider email on file) six months prior to recredentialing due date.

The email provides:

- A link to the Facility Credentialing Application
- A checklist of required supporting documentation
- Instructions on how to complete and return the application

The following forms for recredentialing are accepted.

FACILITY CREDENTIALING APPLICATION																		
ORGANIZATION SPECIALTY - FIRST PRACTICE LOCATION																		
<input type="checkbox"/> Alcohol/Drug Rehabilitation Center (CDU) <input type="checkbox"/> Infusion Therapy Provider <input type="checkbox"/> Ambulance Services <input type="checkbox"/> Suite <input type="checkbox"/> Ambulatory Surgical Center <input type="checkbox"/> Home <input type="checkbox"/> CDU (Free Standing) <input type="checkbox"/> Intensive Outpatient Program <input type="checkbox"/> Charity - Acute Care Hospital <input type="checkbox"/> Laboratory <input type="checkbox"/> Comprehensive Outpatient <input type="checkbox"/> Lithotripter Facility <input type="checkbox"/> Rehabilitation Facility <input type="checkbox"/> Long Term Acute Care Facility <input type="checkbox"/> DME <input type="checkbox"/> Outpatient Cardiac Catheterization Facility <input type="checkbox"/> Emergency Medicine Physicians Group <input type="checkbox"/> Pain Management Program <input type="checkbox"/> Federally Qualified Health Center* <input type="checkbox"/> Psychiatric Hospital (Free Standing) <input type="checkbox"/> Home Health Agency <input type="checkbox"/> Psychiatric Hospital <input type="checkbox"/> Hospice <input type="checkbox"/> Radiation Center <input type="checkbox"/> Hospital																		
*Requirements for Federally Qualified Health Center and Rural Health Clinic may vary by health plan.																		
FACILITY																		
Facility Name: _____ State: _____ ZIP Code: _____ Physical Address: _____ City: _____ State: _____ ZIP Code: _____ Parish/County: _____ Physical Address: _____ Email: _____ Main Phone: _____ Appointment Phone: _____ Fax: _____ Facility Contact: _____ TIN: _____ NPI Number: _____ Office Hours: <table border="1"><tr><td>MON</td><td>TUES</td><td>WED</td><td>THURS</td><td>FRI</td><td>SAT</td><td>SUN</td></tr></table>												MON	TUES	WED	THURS	FRI	SAT	SUN
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? <input type="checkbox"/> Yes <input type="checkbox"/> No Parking? <input type="checkbox"/> Yes <input type="checkbox"/> No Restroom? <input type="checkbox"/> Yes <input type="checkbox"/> No Other: _____ Accessible by public transportation: Bus? <input type="checkbox"/> Yes <input type="checkbox"/> No Courier Service? <input type="checkbox"/> Yes <input type="checkbox"/> No Other: _____ Offers services for the disabled: Text Telephone (TTY)? <input type="checkbox"/> Yes <input type="checkbox"/> No American Sign Language? <input type="checkbox"/> Yes <input type="checkbox"/> No Mental/Physical Impairment Services? <input type="checkbox"/> Yes <input type="checkbox"/> No Other: _____																		
Does the office meet the American With Disabilities Accessibility (ADA) Requirements? <input type="checkbox"/> Yes <input type="checkbox"/> No Patient Ages: (Please check the age ranges of the client populations you treat) <input type="checkbox"/> 0 to 6 <input type="checkbox"/> 7 - 11 <input type="checkbox"/> 12 - 18 <input type="checkbox"/> 19 - 65 <input type="checkbox"/> Over 65 <input type="checkbox"/> All ages Other (Please specify): _____																		

PAGE 1 OF 6

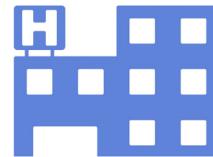
If information is missing from submitted recredentialing application, the provider is then contacted by a recredentialing specialist with a deadline to return the needed information. If not received timely, then provider may be terminated from the network.

SUPPORTING DOCUMENTATION NEEDED FOR RECREENING 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

Positioned for Future Success:
Blue Cross and Blue Shield of Louisiana Enters Into Definitive Agreement to be Acquired by Elevance Health
Deal will result in \$3 billion foundation focused on improving Louisiana
[Read More](#)

Employer Producer Provider State Employee/Retiree Federal Employee Medicare Español

 Louisiana Shop ▾ Find a Doctor or Drug ▾ Save ▾ Wellness

THE RIGHT CARD.
The Right Care.
Your card opens the door to a large network of top doctors to care for you. You can rely on the strength of the Cross and the protection of the Shield.

[Shop Our Plans](#) [Account Login](#)

Find Drugs  Find a Doctor 

All Networks

- All Networks
- Preferred Care PPO
- HMO Louisiana HMO/POS
- Medical Dental Benefit
- Community Blue HMO/POS
- Blue Connect HMO/POS
- BlueHPN
- OchPlus
- Signature Blue HMO/POS
- Precision Blue HMO/POS
- OGB Preferred Care
- OGB MagLocal BR - CommBlue
- OGB MagLocal - BlueConn
- OGB MagLocal Plus - PrefCare
- OGB MagOpenAccess - PrefCare
- OGB Pelican HRA/HSA PrefCare
- Abbeville General
- TQHN
- Blue Connect EPO
- Affinity Health Network

 [d Help?](#)

 Networks Available ▾

★ = Enhanced Tier 1 \$?
● = Tier 1 \$
● = Tier 2 \$\$
● = Tier 3 \$\$\$

- 1 HMO Louisiana HMO/POS
- 1 OGB MagLocal Plus - PrefCare
- 1 OGB MagOpenAccess - PrefCare
- 1 OGB Pelican HRA/HSA PrefCare
- 1 OGB Preferred Care
- 1 Preferred Care PPO
- 2 Abbeville General
- 2 Blue Connect HMO/POS
- 2 Community Blue HMO/POS
- 2 OchPlus
- 2 OGB MagLocal - BlueConn
- 2 OGB MagLocal BR - CommBlue
- 2 Precision Blue HMO/POS
- 2 Signature Blue HMO/POS
- 2 TQHN

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 to 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

Our **Provider Update Request Form** accommodates all your change requests, which are handled directly by our Provider Data Management team.

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

 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)? <input type="checkbox"/> Yes <input type="checkbox"/> 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.

<input type="checkbox"/> Provider Information	<input type="checkbox"/> Electronic Funds Transfer (EFT) Termination or Change	<input type="checkbox"/> Existing Providers Joining a New Provider Group
<input type="checkbox"/> Terminate Network Participation	<input type="checkbox"/> Tax ID Number Change	<input type="checkbox"/> Add New Practice Location (Existing Tax ID)
<input type="checkbox"/> 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

23X07231 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.

<input type="checkbox"/> Demographic Information	<input type="checkbox"/> Electronic Funds Transfer (EFT) Termination or Change	<input type="checkbox"/> Existing Providers Joining a New Provider Group (includes solo providers creating a new provider group)
<input type="checkbox"/> Termination Request	<input type="checkbox"/> Tax ID Number Change	<input type="checkbox"/> Add New Practice Location (Existing Tax ID)
<input type="checkbox"/> 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 the 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.

<input type="checkbox"/> Demographic Information	<input type="checkbox"/> Electronic Funds Transfer (EFT) Termination or Change	<input type="checkbox"/> Existing Providers Joining a New Provider Group (<i>includes solo providers creating a new provider group</i>)
<input type="checkbox"/> Termination Request	<input type="checkbox"/> Tax ID Number Change	<input type="checkbox"/> Add New Practice Location (Existing Tax ID)
<input type="checkbox"/> Remove Practice Location (Existing Tax ID)		

UPDATING YOUR 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.

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

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):							
<input type="checkbox"/> I am available to see patients at least 16 hours per week on a regular basis. <input type="checkbox"/> I see patients here at least one day per month, but less than one day per week on a regular basis. <input type="checkbox"/> I cover or fill-in for colleagues within the same medical group on an as-needed basis only. <input type="checkbox"/> I read tests or provide other services but do not see patients at this location. <input type="checkbox"/> 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: <input type="checkbox"/> No change <input type="checkbox"/> Solo <input type="checkbox"/> Multi-specialty Group <input type="checkbox"/> Single Specialty Group <input type="checkbox"/> Hospital-based <input type="checkbox"/> Hospital-employed <input type="checkbox"/> Healthplan/Payor-owned							
Accepting New Patients		Age Range of Patients (check all that apply)					
<input type="checkbox"/> New <input type="checkbox"/> Existing Only <input type="checkbox"/> Other: _____		<input type="checkbox"/> 0-6 years <input type="checkbox"/> 7-11 years <input type="checkbox"/> 12-18 years <input type="checkbox"/> 19-65 years <input type="checkbox"/> Over 65 <input type="checkbox"/> All Ages <input type="checkbox"/> 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):							
<input type="checkbox"/> I am available to see patients at least 16 hours per week on a regular basis. <input type="checkbox"/> I see patients here at least one day per month, but less than one day per week on a regular basis. <input type="checkbox"/> I cover or fill-in for colleagues within the same medical group on an as-needed basis only. <input type="checkbox"/> I read tests or provide other services but do not see patients at this location. <input type="checkbox"/> 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:							
<input type="checkbox"/> A copy of the Malpractice Liability Insurance Certificate is attached <input type="checkbox"/> 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).							

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.		
<input type="checkbox"/> Demographic Information	<input type="checkbox"/> Electronic Funds Transfer (EFT) Termination or Change	<input type="checkbox"/> Existing Providers Joining a New Provider Group (includes solo providers creating a new provider group)
<input type="checkbox"/> Termination Request	<input checked="" type="checkbox"/> Tax ID Number Change	<input type="checkbox"/> Add New Practice Location (Existing Tax ID)
<input type="checkbox"/> 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 not required for **delegated providers** changing to, or joining a non-delegated group when they are not already credentialed through delegated group for the same specialty.
- 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.: _____

This form is used 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
<input type="checkbox"/>	<input type="checkbox"/>	Specialty	Group/Clinic Name	
<input type="checkbox"/>	<input type="checkbox"/>	Provider National Provider Identifier (NPI)	Group/Clinic National Provider Identifier (NPI)	
<input type="checkbox"/>	<input type="checkbox"/>	Phone Number	Public Facing Email Address (If available)	
<input type="checkbox"/>	<input type="checkbox"/>	Address		
<input type="checkbox"/>	<input type="checkbox"/>	Public Facing Web Address (If available)		

Second Practice Location

Correct	Incorrect	Provider Last Name	First Name	Middle Initial
<input type="checkbox"/>	<input type="checkbox"/>	Specialty	Group/Clinic Name	
<input type="checkbox"/>	<input type="checkbox"/>	Provider National Provider Identifier (NPI)	Group/Clinic National Provider Identifier (NPI)	
<input type="checkbox"/>	<input type="checkbox"/>	Phone Number	Public Facing Email Address (If available)	
<input type="checkbox"/>	<input type="checkbox"/>	Address		
<input type="checkbox"/>	<input type="checkbox"/>	Public Facing Web Address (If available)		

Third Practice Location

Correct	Incorrect	Provider Last Name	First Name	Middle Initial
<input type="checkbox"/>	<input type="checkbox"/>	Specialty	Group/Clinic Name	
<input type="checkbox"/>	<input type="checkbox"/>	Provider National Provider Identifier (NPI)	Group/Clinic National Provider Identifier (NPI)	
<input type="checkbox"/>	<input type="checkbox"/>	Phone Number	Public Facing Email Address (If available)	
<input type="checkbox"/>	<input type="checkbox"/>	Address		
<input type="checkbox"/>	<input type="checkbox"/>	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.

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

Sam Measels

director, Provider Credentialing and Information

sam.measels@bcbsla.com

Vielka Valdez

director, Provider Network Operations

vielka.valdez@bcbsla.com

Kaci Guidry

manager, Provider Data Management & PCDM Status

kaci.guidry@bcbsla.com

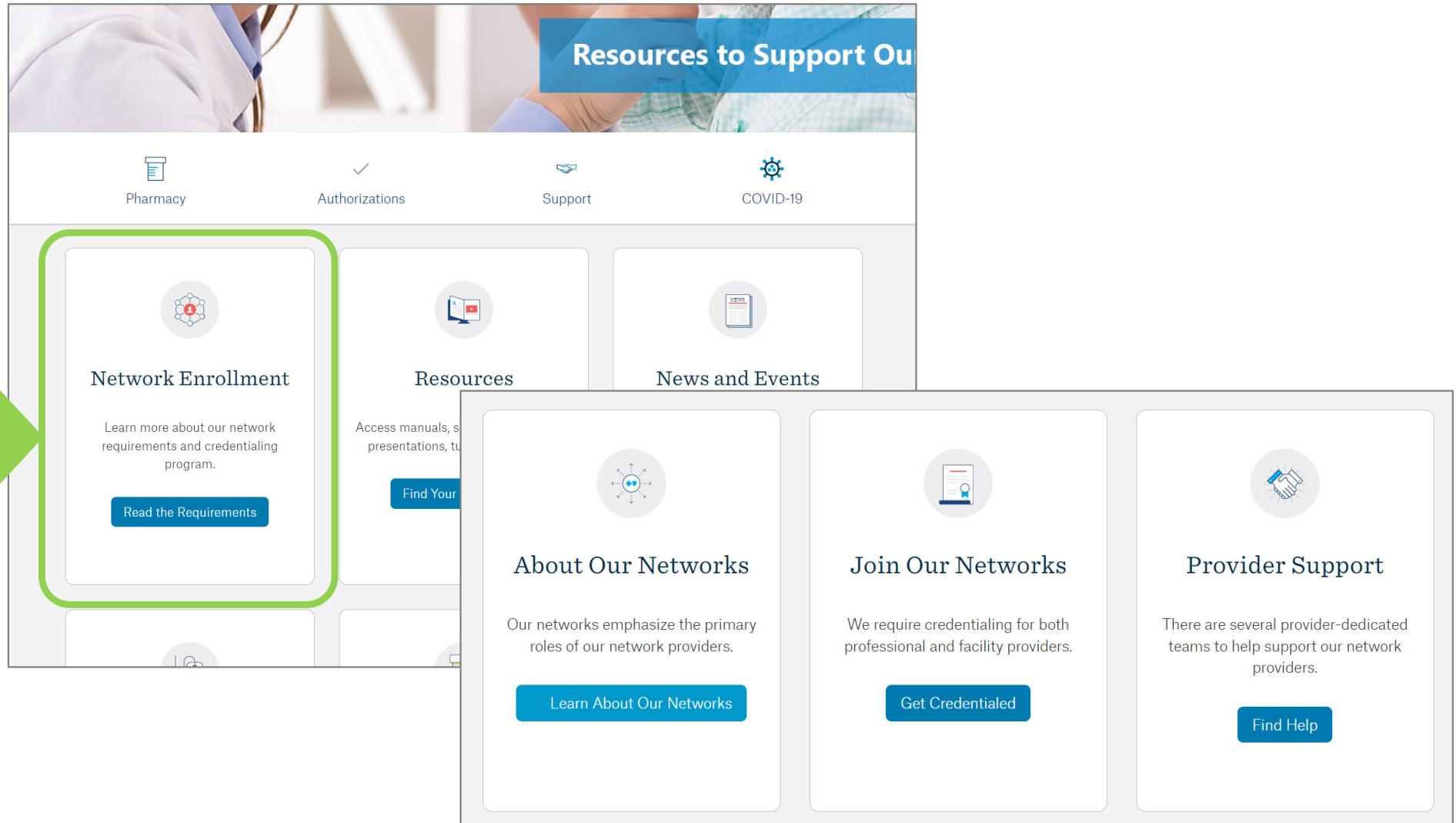
Kristin Ross

manager, Provider Contract Administration

kristin.ross@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



The screenshot shows the BCBSLA Provider Page. At the top, there is a banner with the text "Resources to Support Our". Below the banner, there are four main categories: Pharmacy, Authorizations, Support, and COVID-19. A large green arrow points to the "Network Enrollment" section, which is highlighted with a green border. The "Network Enrollment" section contains a sub-section titled "About Our Networks" with a "Learn About Our Networks" button. Other sections include "Resources", "News and Events", "Join Our Networks", and "Provider Support". Each section has a corresponding icon and a "Read the Requirements", "Find Your", "Learn About Our Networks", "Get Credentialed", and "Find Help" button respectively.

Resources to Support Our

Pharmacy ✓ Support COVID-19

Network Enrollment

Learn more about our network requirements and credentialing program.

Read the Requirements

Resources

News and Events

About Our Networks

Join Our Networks

Provider Support

Find Your

Learn About Our Networks

Get Credentialed

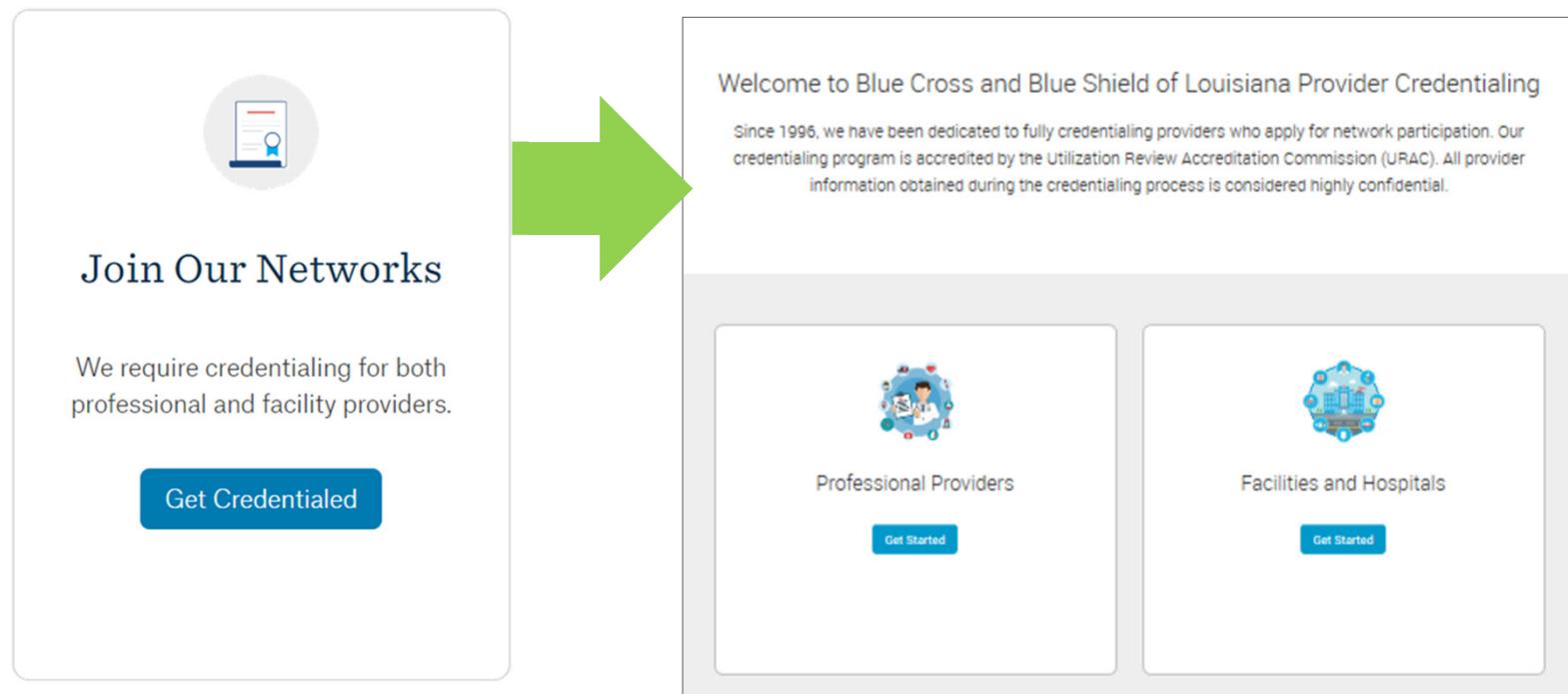
Find Help

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

Overview Credentialing Process Join Our Networks Update Your Information Frequently Asked Questions

Frequently Asked Questions

Credentialing Application and Process

How long does it take to complete the credentialing process?

The process can take up to 90 days for completion once BCBSLA receives all the required information.

How will I know if Blue Cross received my application?

Once your application is finalized through DocuSign®, you will receive a confirmation email to notify you the signing process is complete and submitted to Blue Cross for processing.

What credentialing forms are available online?

BCBSLA offers both the [professional provider application](#) and the [facility credentialing application](#) online through DocuSign. They can be found under the Provider Networks >Join Our Networks section of this site.

Do I need to submit a full credentialing application?

If the provider is **NOT** credentialed, please fully complete and submit the professional initial credentialing packet. Facilities should submit the facility initial credentialing packet.

How do I know what credentialing criteria are required specifically for my specialty type?

We have charts online to help you determine what criteria are needed. These charts are based on provider specialty. They are available on this site under Provider Networks >Join Our Networks and look under the appropriate section ([Professional Provider](#) or [Facilities or Hospitals](#)).

What are the requirements for reimbursement during credentialing?

Select provider types that meet specific criteria may be eligible for reimbursement during the credentialing process.  [Click here](#) for full details.

How do I know if I have been approved for reimbursement during credentialing?

A Record Assignment letter will be emailed to the group correspondence email address on file. If you were approved the letter will state that you were approved and the date the reimbursement during credentialing is effective. If you are not approved, your Record Assignment letter will notify you of the reason.

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)

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

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).

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.

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

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 recipient will complete all required fields with detailed information.
- **“Provider”** - This recipient 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.

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

Clark Wally
DEMO - BCBSL

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.

Easily Complete Forms with DocuSign®

DocuSign Envelope ID: 1A01C5A7-3503-4226-8119-DEA232B827AD

Provider Update Request Form

Complete this form to report updated information on your practice to Blue Cross and Blue Shield of Louisiana.

This request applies to:

Individual Provider Provider Group/Clinic

CURRENT GENERAL INFORMATION

Provider Last Name: (Required - Provider National Provider Identifier (NPI) - Please enter 10 numbers only with no special characters.)

Tax ID Number:

Group/Clinic Name:

Are you a primary care provider (PCP)?

Yes No

Effective Date of Change:

Authorized representative completing this form on behalf of a:

REPRESENTATIVE

Contact Phone Number:

Contact Email Address:

Submission Information (form completed by)

Signature: 

Authorized Representative:

Date: February 18, 2021

Navigation tool guides you through fields.

Instructions correspond to requirement of the active field.

Red outline indicates a required field.

Required - Provider National Provider Identifier (NPI) - Please enter 10 numbers only with no special characters.

Toolips provide information about field requirements.

FINISH **FINISH LATER** **OTHER ACTIONS ▾**

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 screen. PROVIDER understands and agrees that such changes to HEALTH PLAN from time to time under HEALTH PLAN shall be bound by such terms as a condition of PROVIDER's continued access to the iLinkBlue website.

1.2 PROVIDER agrees that it shall furnish, supply, configure and applicable personal computer equipment, telecon configurations and environments, and Internet connect electronic services provided by HEALTH PLAN. PROVIDER shall maintain this computer equipment in proper working order.

1.3 HEALTH PLAN agrees to provide user instruction manual correspondence, to assist the PROVIDER in the proper use of the iLinkBlue website. PROVIDER shall provide telephone and other PROVIDER support Monday through Friday from 8 a.m. - 4:30 p.m. CST, without closure due to announced holidays or any unforeseen circumstances.

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 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 "protected" and "sensitive" 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.

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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 MPI (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 and Acknowledgement

- 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.

<p> Louisiana</p> <p>Administrative Representative Registration Form</p> <p>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.</p> <table border="1" style="width: 100%; border-collapse: collapse;"><tr><td colspan="2" style="background-color: black; color: white; padding: 2px;">GENERAL PROVIDER INFORMATION</td></tr><tr><td colspan="2">Provider Group or Facility Name</td></tr><tr><td colspan="2">Address</td></tr><tr><td>Phone Number</td><td>Provider Group or Facility National Provider Identifier (NPI)</td></tr><tr><td>Individual Provider Name (if applicable)</td><td>Individual Provider NPI (if applicable)</td></tr><tr><td>Tax ID</td><td>Is the Behavioral Health Authorizations Application needed?</td></tr><tr><td colspan="2" style="background-color: black; color: white; padding: 2px;">ADMINISTRATIVE REPRESENTATIVE INFORMATION</td></tr><tr><td>Administrative Representative Name</td><td>Title</td><td>Date of Birth</td></tr><tr><td>Contact Phone Number</td><td colspan="2">Email Address (this will be used for your unique username)</td></tr><tr><td>Additional Phone Number</td><td colspan="2">Additional Email Address</td></tr><tr><td colspan="2" style="background-color: black; color: white; padding: 2px;">MANAGER/OWNER INFORMATION</td></tr><tr><td>Manager/Owner's Name (other than the administrative representative)</td><td>Title</td><td>Date of Birth</td></tr><tr><td>Contact Phone Number</td><td colspan="2">Email Address</td></tr></table> <p>Return Form To: Email: PIMTeam@bcbsla.com Fax: 1-800-515-1128 Attn: Provider Identity Management</p> <p>18W92368 R06/22 Blue Cross and Blue Shield of Louisiana is an independent licensee of the Blue Cross and Blue Shield Association.</p>	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?	ADMINISTRATIVE 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		<p> Louisiana</p> <p>Administrative Representative Acknowledgment Form</p> <p>I understand that I have been designated by my employer/organization (the Organization) as the Administrative Representative for the Organization for the purpose of obtaining and granting access to other Organization employees to the Blue Cross and Blue Shield of Louisiana's (BCBSLA) secure online services (the Secure Services). As such, I am responsible for managing the Organization's access to the Secure Services appropriate users within my Organization and adhering to BCBSLA's guidelines regarding such access and delegation.</p> <p>I agree that Secure Services access will be granted by me and the Organization only to those employees within the Organization who legitimately must have access to the Secure Services in order to fulfill their job responsibilities and only to the extent necessary to fulfill those job responsibilities, all as further described by BCBSLA's guidelines. I am also responsible for managing Organization employees' access to the Secure Services at such time as the employee changes roles or terminates employment with my organization, as applicable. I agree to inform my supervisor or manager of such terminations will be addressed promptly and in accordance with BCBSLA's guidelines.</p> <p>As the Administrative Representative, I understand and agree that the Secure Services are assets of BCBSLA. Any misuse, personal use or use of the Secure Services for any business other than which I am authorized to perform on behalf of the Organization, or other than as set forth in BCBSLA guidelines, is strictly prohibited. I acknowledge that violation of this paragraph may result in the revocation of the access to the Secure Services and/or termination of my employment, including, but not limited to, I further acknowledge that I must at all times respect the confidentiality of all material information or data that I am working with or may have access to in the Secure Services or otherwise on BCBSLA's electronic computer systems. In addition, I agree that I am obligated to protect the assets and/or confidential information in the Secure Services and on BCBSLA's computer systems and to maintain complete secrecy over my username and password that I use to access the Secure Services. Under no conditions shall I reveal my username or password to anyone or allow anyone else access to or use of the Secure Services under my username.</p> <p>I understand that if my role in the Organization changes or if my term of employment ends with the Organization, it is my responsibility to ensure that my duties and access to the Secure Services immediately terminate as well. On behalf of the Organization, I acknowledge and agree that the Organization shall notify BCBSLA immediately of any breach of confidentiality, fraud, or suspected fraud or abuse of which I becomes aware relating to the BCBSLA Secure Services or any third party services or products provided to me in the Secure Services. I further acknowledge that I must immediately notify my Organization and BCBSLA of any such breach of confidentiality, fraud, or suspected fraud or abuse. I further understand that BCBSLA monitors the Secure Services and the access of users thereto. BCBSLA shall report to the Organization any suspected unauthorized access or abuse arising from the Organization's access to the Secure Services and, as a result, my Organization may terminate my access to the Secure Services and/or take legal action as deemed necessary by BCBSLA in its sole discretion.</p> <p>This Acknowledgment may be validly executed via facsimile transmission or through other electronic means showing the signature of the party and such reproduced copy of this Acknowledgment shall constitute an original Acknowledgment for all purposes. Administrative Representative agrees that a facsimile or electronic scanned copy of this document with facsimile or scanned signatures may be treated as an original and will be admissible as evidence in a court of law.</p> <p>For documents with a signature validity of 180 days, will automatically be locked. The administrative representative will need to contact the Provider Identity Management (PIM) Team at PIMTeam@bcbsla.com or 1-800-716-2299, option 5 to reactivate the account. iLinkBlue terminates your account if it remains inactive for one year. If iLinkBlue terminates your user account, the Administrative Representative will need to contact the PIM Team for assistance. You will need to complete a new Administrative Representative Registration Packet. The packet is available on our website at www.bcbsla.com/providers.</p> <p style="text-align: center;">SIGNATURE PAGE FOLLOWS</p>
GENERAL PROVIDER INFORMATION																																
Provider Group or Facility Name																																
Address																																
Phone Number	Provider Group or Facility National Provider Identifier (NPI)																															
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The Administrative Representative Registration packet is also available online at www.bcbsla.com/providers >Electronic Services >Admin Reps.