Provider Group/Facility Record Application (RA-02)

Dear Health Care Provider,

This form is used by Blue Shield of California (Blue Shield) and/or Blue Shield of California Promise Health Plan (Blue Shield Promise) to establish a provider group or facility record for the purpose of supporting claims processing. Once the application process is complete, Blue Shield and/or Blue Shield Promise will confirm eligibility of the applicant for claims submission, using the contact information provided.

Instructions
Identify the provider group or facility requiring a billing record and complete all fields with the group or facility information. Populate page three of this application with all **required data elements** for professional practitioners at the location. For additional practitioners, use page three as a template. One application will be used per service location. Attach all required documentation, as outlined below, and return this form to Blue Shield and/or Blue Shield Promise via email at **BSCProviderInfo@blueshieldca.com**. This form may be completed electronically.

Required Documentation
This request will not be initiated until all the required documentation indicated below is received by Blue Shield and/or Blue Shield Promise. Failure to provide the required documentation will result in no action being taken.

- Include the licensure/certification or other supporting document(s) for the type of service and name provided.
  - **You must indicate issue date.**
  - **You must indicate issuing agency or governing body.**
  - **Facility license/certification may be required for each service location.**

- If you intend to submit claims using a legal entity name filed with the California Secretary of State, submit a copy of the approved filing.

- If you intend to submit claims using an Employer Identification Number (EIN) or Tax Identification Number (TIN), submit a signed W-9 or Department of Treasury/Internal Revenue Services (IRS) tax document.

- Provide proof of legal authorization to use the listed DBA.
  - **If a DBA is required to be registered with the State Licensing Board, include a photocopy of the Fictitious Name Permit from the State Licensing Board.**
  - **All other providers: If you are incorporated and using an incorporated name, only a photocopy of your Articles of Incorporation is required. If you are not incorporated and using a fictitious name, a Fictitious Name Statement issued by the county is required.**

Additional Information
This form is only used to create a new provider group or facility record. To update an existing provider group or facility record, please complete the Provider Group/Facility Information Change Form (Form ICF-02). This form is not an agreement to participate in the Blue Shield or Blue Shield Promise provider network. For information about joining either network, please contact our Provider Information and Enrollment Department via email at **BSCProviderInfo@blueshieldca.com.**

Sincerely,

Angela Young
Senior Manager, Operations
Provider Network Administration

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By submitting this form applicant certifies on behalf of this provider record that all information included on this form is true, accurate and complete. Any false statements, the concealment of material fact, or the use of false documents may lead to prosecution under applicable federal or state laws. Applicant certifies under penalty of perjury that the foregoing is true and correct.

Please type or print information in all fields:

Provider Name/Doing Business as Name (DBA)

Service Location Address Professional staff will be listed on the next page. Additional location(s) will require a separate application.

Street Address (include suite number):		
City:	State:	ZIP code:
Phone Number:	Fax Number:	
Office hours:		

Billing Information

If same as the service location, please check this box:	☐

Street Address (include suite number):		
City:	State:	ZIP code:
Phone Number:	Fax Number:	
Office Hours:		

Business email for administrative use:
Primary Specialty/Type of Service:
Secondary Specialty:
License/Certification/Permit Number (attach copy of document):
License/Certification/Permit Issuing Body:
Legal Entity Name:
EIN/TIN (attach pre-printed tax document/W-9):
National Provider Identifier (NPI):

Wheelchair Access? ☐ Yes ☐ No	
Qualified Medical Interpreter:	☐ Cantonese ☐ Spanish ☐ Russian ☐ Mandarin
	☐ Vietnamese ☐ Korean ☐ N/A
Non-roster Member Languages:	It not applicable, check this box: ☐

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Identify all professional practitioners at the above location. Additional practitioners can be added using a copy of this page.

Roster Member	
Practitioner Full Name	
Practitioner Title	
Practitioner Degree	
License Number	
License Issuing Body	
NPI	
Practitioner Language	
Hospital Affiliation Name(s) (For MD or DO)	
Roster Member	
Practitioner Full Name	
Practitioner Title	
Practitioner Degree	
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