Individual Practitioner Record Application (RA-01)

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 an individual practitioner 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 individual practitioner requiring a billing record and complete all fields with the practitioner information. For additional locations, use page three of this document as a template. 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

- Include the licensure/certification or other supporting document(s) for the type of service and name provided:
  - **You must indicate the issue date.**
  - **You must indicate the issuing agency or governing body.**
- 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), please submit a signed W-9 or Department of Treasury/Internal Revenue Service (IRS) tax document.

Additional Information

This form is only used to create new individual practitioner records. To update an existing individual practitioner record, please complete the Individual Practitioner Information Change Form (Form ICF-02). This form is not an agreement to participate in the Blue Shield and/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:

First Name, Middle Name and Last Name:

Gender:

Male ☐	Female ☐

Service location address
For more than one location, please continue listing on the table provided on page 3 of this form.

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 Number (attach copy of document):

License/Certification Issuing Body:

Social Security Number (SSN):

National Provider Identifier (NPI):

EIN/TIN (attach pre-printed tax document/W-9):

Telecommunication Device for the Deaf (TDD):

Practitioner's Languages:

Wheelchair Access? ☐ Yes ☐ No	
Qualified Medical Interpreter:	☐ Cantonese ☐ Spanish ☐ Russian ☐ Mandarin
	☐ Vietnamese ☐ Korean ☐ N/A
Hospital Affiliation (full hospital name):	It not applicable, check this box: ☐

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Please complete the table below to indicate additional service locations.

Location 1	
Street address:	City, State, ZIP code:
Phone number:	Fax number:
Business email:	Wheelchair access? ☐ Yes ☐ No
Qualified Medical Interpreter: ☐ Cantonese ☐ Spanish ☐ Russian ☐ Mandarin ☐ Vietnamese ☐ Korean ☐ N/A	
Non-roster member languages:	Office Hours:
Location 2	
Street address:	City, State, ZIP code:
Phone number:	Fax number:
Business email:	Wheelchair access? ☐ Yes ☐ No
Qualified medical interpreter: ☐ Cantonese ☐ Spanish ☐ Russian ☐ Mandarin ☐ Vietnamese ☐ Korean ☐ N/A	
Non-roster member languages:	Office hours:
Location 3	
Street address:	City, State, ZIP code:
Phone number:	Fax number:
Business email:	Wheelchair access? ☐ Yes ☐ No
Qualified medical interpreter: ☐ Cantonese ☐ Spanish ☐ Russian ☐ Mandarin ☐ Vietnamese ☐ Korean ☐ N/A	
Non-roster member languages:	Office hours:
Location 4	
Street address:	City, State, ZIP code:
Phone number:	Fax number:
Business email:	Wheelchair access? ☐ Yes ☐ No
Qualified medical interpreter: ☐ Cantonese ☐ Spanish ☐ Russian ☐ Mandarin ☐ Vietnamese ☐ Korean ☐ N/A	
Non-roster member languages:	Office hours: