Health Delivery Organization (HDO) Application

This application is submitted to: **Blue Shield of California** herein, this Healthcare Organization[1].

I. INSTRUCTIONS (Please read before filling out the application)

Please complete a separate application for each location. This form should be typed or legibly printed in black or blue ink. All sections must be filled out and all questions answered; if an area does not apply, write N/A. If more space is needed, attach additional sheets and reference the question being answered. Please do not use abbreviations when completing the application. Incomplete application will not be processed and will be returned.

II. IDENTIFYING INFORMATION

Business Name:				
DBA:				
Office Address (If more than one site, please complete a separate application for each):			Telephone Number: Fax Number:	
City:	State:	Zip:	Tax ID # (Include W-9 form):	
Office Contact/Manager:	Tel #:		Fax #	Email:
Credentialing Contact Person:	Tel #:		Fax #	Email:

Type of Facility (Check all those which apply and include documentation):

☐ Hospital ☐ Home Health Agency ☐ Skilled Nursing Facility ☐ Laboratory

☐ Durable Medical Equipment ☐ Free Standing Surgical Center ☐ Radiology Facility ☐ Mental Health Facility

☐ Other, please specify:

Office Hours of Operation:

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

III. MAILING/BILLING ADDRESS

Credentialing Mailing Address (if different from above):			Billing Address (if different from above Address):		
City:	State:	Zip:	City:	State:	Zip:
Telephone Number: Fax Number:			Telephone Number: Fax Number:		
Mailing Contact: Title:			Billing Contact: Title:		

IV. LICENSE/REGISTRATION INFORMATION (Please provide copies of documentation)

State:	License Number:	Issue Date:	Expiration Date:
DEA:			
City/Business License:			
Fictitious Name Permit (FNP) / CA Business Portal:			
National Provider Identifier (NPI) Number:			**NA**
Medicare Provider Number:			**NA**
Medi-Cal Provider Number:			**NA**

V. ACCREDITATION/CERTIFICATION (Please provide copies of documentation)

Include certifications by board(s) which are duly organized and recognized by:

- National Committee for Quality Assurance (NCQA)
- Joint Commission on Accreditation of Healthcare Organizations (TJC)
- American Accreditation Association for Accreditation for Ambulatory Surgery Facilities (AAAASF)
- Accreditation Association for Ambulatory Health Care (AAAHC)
- Community Health Accreditation Program (CHAP)
- URAC
- Continuing Care Accreditation Commission (CCAC)
- The Medical Quality Commission
- Other, list below

Accrediting/Certifying Agency:	Date Certified/Recertified	Expiration Date

VI. PROFESSIONAL LIABILITY (Attach current insurance face sheet)

Current Insurance Carrier:	Policy Number:	Effective Date: Expiration Date:
Mailing Street Address:		Coverage Amount Per Occurrence:
City: / State: / Zip:		Aggregate:

Coverage Type:
☐ Occurrence based ☐ Claims based

If Claims based, does this facility have tail coverage?
☐ Yes ☐ No

Please explain any surcharges/restrictions to your professional liability coverage: (attach additional pages if necessary)

VII. FACILITY OVERVIEW

Do you employ any non-medical physician providers (i.e. physician's assistants, nurse practitioners, nurse mid-wives, registered nurses, certified nurse assistant, etc.)? ☐ No ☐ Yes If yes, please list and include copies of licensure (attach extra sheet if necessary):

Name:	Type of Provider:	CA License Number:

VIII. LABORATORY SERVICES

If you provide direct laboratory services, please indicate the TIN utilized and provide Clinical Laboratory Information Act (CLIA) information. Attach a copy of your CLIA certificate or waiver if you have one.

Do you have a CLIA certificate? ☐ Yes ☐ No	Certificate Number:	Expiration Date:
Do you have a CLIA waiver? ☐ Yes ☐ No	Certificate Number:	Expiration Date:

ATTESTATION:

I, the undersigned authorized agent, hereby attest and certify that all statements on this application are true, accurate, and correct to the best of my knowledge. I fully understand that any falsification of information or omissions from this application may be grounds for denial of this application as a Blue Shield of California Participating Provider or cause for summary dismissal from Blue Shield of California. During the time this application is being processed and anytime thereafter, I agree to update the application should there be any change in the information provided and to supply Blue Shield of California with documentation of current licensure, accreditation and malpractice coverage. I am aware of my right to review my credentialing information at anytime by sending a written request to the Credentialing Department at **Blue Shield of California, 601 12th Street, Oakland, CA 94612** or by **email to BSC_FacCred@Blueshieldca.com**. The Credentialing Department will notify the undersigned within 72 hours of the request receipt and will provide date and time when such information will be available for review at Blue Shield of California Credentialing Department. I acknowledge that action on this application will be delayed until all required information is received and/or verified. A photocopy of this document shall be as effective as the original.

Print Name of Authorized Agent: _____ Title: _____

Signature of Authorized Agent: _____ Date Signed: _____
(Stamped signature is not acceptable) (Not accepted if not dated)

blue california

Health Delivery Organization Application

As part of an effort to provide quality care to our members, Blue Shield of California requires contracted Health Delivery Organizations (HDO) go through the credentialing process, as required by NCQA, CMS, and DMHC.

In order to expedite the Credentialing Application process in timely manner, please complete the attached HDO Credentialing Application in its entirety. In addition, please complete and provide the following as instructed below:

- **Complete, sign and date the application:**
  - Health Delivery Organization's Attestation
- **Copy of current state license (if applicable)**
  - If no state license, please provide city or business license, Certificate of Occupancy, Fictitious Name Permit)
- **Copy of current professional liability insurance face sheet showing the facility's name, coverage amount ($1M/$3M for All and $1M to $1M for Behavior Analysts) and expiration date**
- **Copy of current of accreditation certificate (if applicable)**
  - If the facility is not accredited, please provide current copy of DHS or CMS facility site survey
- **Copy of Medicare Certificate**
- **Copy of Medicaid Certificate**
- **NPI Number**
- **Copy of current CLIA or waiver of CLIA certificate (if applicable).**
- **SAMHSA Certificate (OTP Opioid Treatment Program only)**

Please submit the application along with copy of all the required documents to:

Blue Shield of California
Attn: **Credentialing Department**
E-mail: BSC_FacCred@Blueshieldca.Com *(please note: Place and underscore between BSC and FacCred)*

Should you have any questions, please feel free to contact credentialing department via the above email.

Sincerely,

[insert digital signature]

Sender's Name
Sender's Title

Enclosure