Provider Group/Facility Application Form (RA-02)

The data provided on this form or an additional form with equivalent data is used by Blue Shield of California (Blue Shield) and/or Blue Shield of California Promise Health Plan (Blue Shield Promise) to establish a record for a provider group or facility 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 per service location is required.

Attach all required documentation, as outlined below, and return this form to Blue Shield and/or Blue Shield Promise via email: 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 to process the application.

- 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.
  - 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), please submit a signed W-9 or Department of Treasury/Internal Revenue Service (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 group or facility record, please complete the Provider Group/Facility Information Change Form (FormICF-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

In accordance with regulatory requirements, Blue Shield reports and publishes a maximum number of in-person service locations for practitioners:

Primary Care Physicians (PCPs)
One practitioner may not be listed as a primary care physician (PCP) in more than seven (7) in-person service location addresses across the entire network. This requirement applies even if the practitioner is listed as a PCP on rosters for multiple, separately contracted IPA/medical groups. The aggregated total for providing in-person services as a PCP must not exceed seven (7) service locations in Blue Shield's entire provider directory.

Physician Specialists:
One physician specialist may not be listed as a specialist in more than eleven (11) in-person service location addresses across the entire network. This requirement applies even if the practitioner is listed as a specialist on rosters for multiple, separately contracted IPA/medical groups. The aggregated total for providing in-person services as a specialist must not exceed eleven (11) service locations in Blue Shield's entire provider directory.

The above limitation requirements only apply to in-person service locations for each PCP or specialist practitioner. No limits apply to locations where ONLY telehealth or virtual care services ONLY are provided. If the practitioner also provides services to Blue Shield members in person at the location, however, it will be counted as an in-person services location.

Provider Group/Facility Application (RA-02), cont'd.

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.

The provider group/facility email entered into this form will be tied to your provider portal account notifications and used for account-specific outreach.

Please type or print information in all fields.

Provider name/ doing business as (dba):		Legal entity name:	
EIN/TIN (attach pre-printed tax document/W-9):		National provider identifier (NPI):	
Primary specialty/ type of service	License/certification/ permit issuing body:	License/certification number (attach copy of document)	
Patient visit options (all that apply): ☐ Telehealth visits ☐ In-person visits		Website URL:	
Provide service location address below. Additional service location(s) for your provider group/facility will require a separate application.			
Practice street address:	City:	State:	ZIP code:
Location appointment phone number:	Location fax number:	After hours phone numberif applicable):	
Provider Group/Facility Business email:		Wheelchair access? ☐ Yes ☐ No	

Office days and hours (complete all days, using N/A if not available):

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

Qualified medical interpreter: ☐ Cantonese ☐ Korean ☐ Mandarin ☐ Russian ☐ Spanish ☐ Vietnamese

Non-roster member languages:

Handicap accessible (all that apply):

☐ Exam room	☐ Exterior handicap accessible	☐ Internal handicap accessible	☐ Medical equipment
☐ Parking	☐ Table scale	☐ Wheelchairs available	

Billing information

Address (if different from service location):	City:	State:	ZIP code
Phone:	Fax:		

Paperless remittance advice (replaces paper EOB)

Direct electronic data interchange (EDI) trading partners may receive 835 electronic remittance advices (ERA) directly from Blue Shield / Blue Shield of California Promise Health Plan.

Authorize a vendor/clearinghouse to receive ERA data to automate your payment posting on your behalf.
This information will certify that the Third Party named below is authorized to receive the provider electronic remittance advice (also known as the 835). Paper Explanation of Benefits will be discontinued at the time of enrollment.

ERA election: ***Select and document only one.*** **The third-party vendor/clearinghouse documented below is authorized to receive ERAs on behalf of your provider organization**. The trading partner is enrolled to receive ERA via secure file transfer protocol (SFTP) directly from Blue Shield/Blue Shield Promise.

Name:	Phone:	Fax:	
Street address:	City:	State:	ZIP code:
Name of technical contact:	Email address:		

Provider Group/Facility Application (RA-02), cont'd.

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.

Identify all professional practitioners at the above service location indicated on page two. Additional practitioners for that service location can be added using a copy of this template.

Roster Practitioner 1		**Roster practitioner 2**	
Licensed practitioner's name:		Licensed practitioner's name:	
Title:	Degree:	Title:	Degree:
License number:		License number:	
License issuing body:		License issuing body:	
Practitioner's NPI:		Practitioner's NPI:	
Supervising physician's name (if applicable):		Supervising physician's name (if applicable):	
Supervisor's NPI:		Supervisor's NPI:	
Hospital affiliation name(s) (for MD or DO):		Hospital affiliation name(s) (for MD or DO):	
Check here if practitioner is hospital-based: ☐		Check here if practitioner is hospital-based: ☐	
Practitioner language(s) spoken:		Practitioner language(s) spoken:	
Practitioner ethnicity:		Practitioner ethnicity:	
Patient acceptance: ☐ Current patients only ☐ New and existing patients	Gender limitations: ☐ N/A ☐ Male only ☐ Female only	Patient acceptance: ☐ Current patients only ☐ New and existing patients	Gender limitations: ☐ N/A ☐ Male only ☐ Female only
Lowest age:		Lowest age:	
Highest age:		Highest age:	
Roster Practitioner 3		**Roster practitioner 4**	
Licensed practitioner's name:		Licensed practitioner's name:	
Title:	Degree:	Title:	Degree:
License number:		License number:	
License issuing body:		License issuing body:	
Practitioner's NPI:		Practitioner's NPI:	
Supervising physician's name (if applicable):		Supervising physician's name (if applicable):	
Supervisor's NPI:		Supervisor's NPI:	
Hospital affiliation name(s) (for MD or DO):		Hospital affiliation name(s) (for MD or DO):	
Check here if practitioner is hospital-based: ☐		Check here if practitioner is hospital-based: ☐	
Practitioner language(s) spoken:		Practitioner language(s) spoken:	
Practitioner ethnicity:		Practitioner ethnicity:	
Patient acceptance: ☐ Current patients only ☐ New and existing patients	Gender limitations: ☐ N/A ☐ Male only ☐ Female only	Patient acceptance: ☐ Current patients only ☐ New and existing patients	Gender limitations: ☐ N/A ☐ Male only ☐ Female only
Lowest age:		Lowest age:	
Highest age:		Highest age:	