Individual Practitioner Record Application (RA-01)

The data provided on this form or 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 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.

Individual Practitioner Application (RA-01)

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, last name:	**Practitioner national provider identifier (NPI):**	
Primary Specialty/type of service:	**Social security number (SSN):**	
Secondary specialty/type of service:	**License/certification/permit issuing body:**	
License/certification number (attach copy of document):	**EIN/TIN (attach pre-printed tax document W-9):**	
Hospital affiliation (full hospital name): Check if practitioner is hospital based:	**Practitioner's gender:** Male: Female:	**Practitioner's ethnicity:**
Supervising physician(if applicable): Supervisor's name:	**Practitioner's languages:**	
Supervisor's NPI:	**Website URL:**	

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. The trading partner is enrolled to receive ERA via secure file transfer protocol (SFTP) directly from Blue Shield/Blue Shield Promise.

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

blue california

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Please complete the table below for service location and billing address information.

Service and billing information for location 1

Street address:

Wheelchair access?
Yes No

Business email:

City:

State:

ZIP code:

Patient visit options (select all that apply):
Telehealth visits In-person office visits

Phone number:

Fax number:

After hours phone number (if applicable):

Patient acceptance:
Accepting new and existing patients:
Accepting current patients only:
Gender limitations: N/A
Male only Female only

Lowest age: Highest age:

Qualified medical interpreter:
Cantonese Spanish Russian
Vietnamese Korean

Non-roster member languages:

Office hours:

Handicap accessible (select all that apply):
Table scale Medical equipment Restroom Parking Exam room Wheelchairs available
Internal handicap accessible Exterior handicap accessible Handicap accessible

Billing street address if different from service location:

Billing city:

Billing state:

Billing ZIP code:

Billing phone number:

Billing fax number:

Service and billing information for location 2

Street address:

Wheelchair access?
Yes No

Business email:

City:

State:

ZIP code:

Patient visit options (select all that apply):
Telehealth visits In-person office visits

Phone number:

Fax number:

After hours phone number (if applicable):

Patient acceptance:
Accepting new and existing patients
Accepting current patients only
Gender limitations: N/A
Male only: Female only:

Lowest age: Highest age:

Qualified medical interpreter:
Cantonese Spanish Russian
Vietnamese Korean Mandarin

Non-roster member language:

Office hours:

Handicap accessible (select all that apply):
Table scale Medical equipment Restroom Parking Exam room Wheelchairs available
Internal handicap accessible Exterior handicap accessible Handicap accessible

Billing street address if different from service location:

Billing city:

Billing state:

Billing ZIP code:

Billing phone number:

Billing fax number: