Provider Group/Facility Record Application (RA-02)

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 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: **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**.

Provider Group/Facility Record Application (RA-02)

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):	**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: select all that apply:** Telehealth visits ☐ In-person office visits ☐
Website URL:	

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

Street address:	**City:**	**State:**	**ZIP code:**
Location phone number:	**Location fax number:**	**After hours phone number (if applicable):**	
Wheelchair access? Yes ☐ No ☐		**Business email:**	
Non-roster member languages:		**Office hours:**	

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

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

Billing address if different from service location:	**Billing city:**	**Billing state:**	**Billing ZIP code:**
Billing phone:	**Billing 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. The trading partner is enrolled to receive ERA via secure file transfer protocol (SFTP) directly from Blue Shield/Blue Shield Promise.

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

Provider Group/Facility Record Application (RA-02)

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 location. Additional practitioners can be added using a copy of this page.

Roster Member 1		Roster Member 2	
Practitioner full name:		**Practitioner full name:**	
Practitioner title:		**Practitioner title:**	
Practitioner degree:		**Practitioner degree:**	
License Number:		**License number:**	
Practitioner ethnicity:		**Practitioner ethnicity:**	
License issuing body:		**License issuing body:**	
NPI:		**NPI:**	
Supervising physician's name (if applicable):		**Supervising physician's name (if applicable):**	
NPI:		**NPI:**	
Practitioner language(s):		**Practitioner language(s):**	
Hospital affiliation name(s) (For MD or DO):	Check if practitioner is hospital based: ☐	**Hospital affiliation name(s) (For MD or DO):**	Check if practitioner is hospital based: ☐
Patient acceptance: Accepting new and existing patients ☐ Accepting current patients only ☐	**Gender limitations:** N/A ☐ Male only ☐ / Female only ☐ Lowest age / Highest age	**Patient acceptance:** Accepting new and existing patients ☐ Accepting current patients only ☐	**Gender limitations:** N/A ☐ Male only ☐ / Female only ☐ Lowest age / Highest age

Roster Member 3		Roster Member 4	
Practitioner full name:		**Practitioner full name:**	
Practitioner title:		**Practitioner title:**	
Practitioner degree:		**Practitioner degree:**	
License number:		**License number:**	
Practitioner ethnicity:		**Practitioner ethnicity:**	
License issuing body:		**License issuing body:**	
NPI:		**NPI:**	
Supervising physician's name (if applicable):		**Supervising physician's name (if applicable):**	
NPI:		**NPI:**	
Practitioner language(s):		**Practitioner language(s):**	
Hospital affiliation name(s) (For MD or DO):	Check if practitioner is hospital based: ☐	**Hospital affiliation name(s) (For MD or DO):**	Check if practitioner is hospital based: ☐
Patient acceptance: Accepting new and existing patients ☐ Accepting current patients only ☐	**Gender Limitations:** N/A ☐ Male only ☐ / Female only ☐ Lowest age / Highest age	**Patient acceptance:** Accepting new and existing patients ☐ Accepting current patients only ☐	**Gender limitations:** N/A ☐ Male only ☐ / Female only ☐ Lowest age / Highest age