Blue Shield of Calfornia Promise Health Plan HMO

Provider Data Confirmation – Individual Practitioner

Dear Practitioner,

In an effort to ensure that your demographic information is accurate and properly displayed in our provider directories, we request that you complete and return this Provider Data Confirmation form.

Throughout the year, you may receive multiple requests via phone call, fax, email or United States Postal Service to validate your information. **It is imperative that all requests to validate your demographic information be responded to promptly.**

***IF YOU DO NOT RESPOND WITHIN THIRTY (30) BUSINESS DAYS, PROVIDER WILL BE REMOVED FROM BLUE SHIELD OF CALFORNIA PROMISE HEALTH PLAN’s PROVIDER DIRECTORY OR DIRECTORIES.***

Blue Shield of California Promise Health Plan is an independent licensee of the Blue Shield Association.

**Your response is due by: XX/XX/2018**

Other channels of communicating any type of inaccuracies can be made using the Blue Shield of

Calfornia Promise Health Plan email at [BSCproviderinfo@blueshieldca.com](mailto:BSCproviderinfo@blueshieldca.com). Blue Shield of

Calfornia Promise Health Plan has also created a **Provider Data Form** which can be found on Blue

Shield of Calfornia Promise Health Plan website <https://www.blueshielca.com>/promise and is

available 24/7.

**Important Notice Regarding Senate Bill 137**

* **SB137 requires that providers respond to requests from health plans to validate their information.**
* **Health plans are required to remove providers from directory listings if they do not respond to validation efforts.**

On the left side of this form we have listed your provider data information currently on file. If this data is correct, please return a signed form without making any changes. If data is missing or incorrect, provide the updated information in the column on the right, and return the signed form. **Please complete and return this form even if there are no updates.**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| HMO Provider Data on File | Complete if HMO Data on File is Incorrect or Missing ***(No Changes- Leave Blank)*** | | | |
| Blue Shield of Calfornia Promise Health Plan Provider ID number and Vendor ID:  **«PROV\_ID»/«Vendor ID»** |  | | | |
| IPA/Medical Group Affiliation:  **Blue Shield Promise Health Plan Direct** |  | | | |
| **Contracted for line of business:** | **Medi-Cal Medicare Cal MediConnect**  **Yes No Yes No Yes No** | | | |
| Practitioner Name:  **«FName LName, Suffix»** |  | | | |
| California Medical License Number:  **«LICENSE\_NO»** |  | | | |
| Practitioner NPI:  **«NPI»** |  | | | |
| **HMO Provider Data on File** | Complete if HMO Data on File is Incorrect or Missing ***(No Changes- Leave Blank)*** | | | |
| Service Location Address:  *Where patients receive service*  **«Address1, Address 2, City, State Zip»** |  | | | |
| Service Location Phone Number:  *Centralized phone number where patients can call to schedule an appointment*  **«BUS\_PHONE»** |  | | | |
| FAX Number:  *Centralized fax number to receive important documents from Blue Shield of Calfornia Promise Health Plan Health Plan such as referrals and authorizations*  **«FAX\_PHONE»** |  | | | |
| Email Address:  **Do you authorize Blue Shield of Calfornia Promise Health Plan to display email address?**  *This email address is intended for patient communication, regularly monitored, and maintained with state and federal health privacy laws.*  **If the answer to the question above was “Yes” please provide your email address.** | **Yes No**  **Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | |
| Gender:  **«SEX»**  *If above data shows “unknown” please advise correct gender* | **Male Female** | | | |
| Provider Office Hours:  **«Hours»** | **Mega Reg** | | | |
| Provider After Hours Telephone Number:  **<Prov\_After\_Hour>** | **Mega Reg** | | | |
| Tax Identification Number:  **<TIN>** |  | | | |
| Clinic Name:  **<Clinic Name>** | **Clinic Name:** |  | | |
|  |  | | |
| Practitioner Specialty:  **«Practitioner\_Specialty\_1»**  **«Practitioner\_Specialty\_2»** |  | | | |
| Available to a subset of enrollees:  (**Example:** Only Native American enrollees may access a provider associated with a Native American tribe, or only enrollees who are students may access a provider at the college’s student health service) | **Yes No CMS** | | | |
| Available only to patients who pay an annual fee or retainer:  (Applicable to Providers who practice concierge medicine) | **Yes No CMS** | | | |
| Available only for home visits and do not see patients at a physical office location: | **Yes No CMS** | | | |
| Physican Website URL: (If Available)  **<Physician\_Website>** | **Mega Reg** | | | |
| **HMO Provider Data on File** | Complete if HMO Data on File is Incorrect or Missing ***(No Changes- Leave Blank)*** | | | |
| **Provider Panel Status:**  *Note: Panel Status will reflect provider directories based on how this question is answered. If you are retired or no longer in practice, Blue Shield of Calfornia Promise Health Plan will remove your information from the directories.* | **Medi-Cal Panel**  **Accepting new patients**  **Accepting existing patients**  **Available by referral only**  **Available only through a hospital or facility**  **Not accepting new patients.**  **Retired or No Longer in Practice**  **Effective Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | |
| **Medicare Panel**  **Accepting new patients**  **Accepting existing patients**  **Available by referral only**  **Available only through a hospital or facility**  **Not accepting new patients.**  **Retired or No Longer in Practice**  **Effective Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | |
| **Cal MediConnect Panel**  **Accepting new patients**  **Accepting existing patients**  **Available by referral only**  **Available only through a hospital or facility**  **Not accepting new patients.**  **Retired or No Longer in Practice**  **Effective Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | |
| Age Restricition:  **«MIN\_AGE\_LMT - MAX\_AGE\_LMT»** |  | | | |
| Board Certified:  **<Board\_Cert\_YN>**  If yes, Board Certified Expiration Date.  **<Board\_Cert\_Exp\_Date>**  Board Certified Specialty Type:  **<Board\_Spec\_1>; <Board\_Spec\_2>** | **Yes No** | |  | |
| **Expiration Date:** | |  | |
| **Board Cert**  **Specialty Type:** | |  | |
|  | |  | |
| Hospital Admitting Privileges:  *If you have additional privileges that are not included please list them and the city of where that hospital is located.*  **«Hospital\_Admitting\_Privileges\_1»**  **«Hospital\_Admitting\_Privileges\_2»**  **«Hospital\_Admitting\_Privileges\_3»**  **«Hospital\_Admitting\_Privileges\_4»** | **Hospital Admitting Privileges 1:** | | | |
| **Hospital Admitting Privileges 2:** | | | |
| **Hospital Admitting Privileges 3:** | | | |
| **Hospital Admitting Privileges 4:** | | | |
| Languages spoken:  **«Languages\_For\_Display»** |  | | | |
| American Sign Language:  ***By practitioner or clinical staff*** | **Yes No** | | | |
| Language line interpreter services**:** | **Yes No CMC** | | | |
| **HMO Provider Data on File** | Complete if HMO Data on File is Incorrect or Missing ***(No Changes- Leave Blank)*** | | | |
| Provider has completed cultural competence training? | **Yes No CMC** | | | |
| Provider has access to skilled medical interpreters on site: | **Yes No CMC** | | | |
| Language Interpreter Non-English Languages:  **«Languages\_For\_Display»**  **«Languages\_For\_Display»** |  | | | |
| Accommodations for those with physical disabilities: | **Parking  Restroom CMC**  **Exam Room  Other:**  **Table**  **External Building**  **Internal Building** | | | |
| Public transportation (within 1/2 mile from provider site): | **Yes No CMC** | | | |
| Special Expertise: | **Physical Disabilities?**  **Chronic Illness?**  **HIV/AIDS?**  **Serious Mental Illness?**  **Homelessness?**  **Deafness or Hard-of-Hearing?**  **Blindness or Visual Impairment?**  **Co-occurring Disorders?**  **If any other, please indicate** | | | **Yes No**  **Yes No**  **Yes No**  **Yes No**  **Yes No**  **Yes No**  **Yes No**  **Yes No**  **Other:       CMC** |
| Accepting Medi-Medi: | **Yes No CMS** | | | |

Once completed, **fax this form to Blue Shield of Calfornia Promise Health Plan Provider Relations Department at 323-889-5418.**

Should you have any questions, please contact Provider Relations Department at 800-468-9935 (option #7) or by e-mail at [demographicupdates@blueshieldca.com](mailto:demographicupdates@blueshieldca.com)

In order to protect our practitioners from unauthorized changes to their files, we require that changes be accompanied by a signature of the practitioner or person authorized by the practitioner.

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# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Contact Phone Number Date