Blue Shield of California Behavioral Health Network Application for Facilities

Email completed application and documents to Blue Shield of California at BH_Facilities@blueshieldca.com

1. Instructions

A separate application is required for each location. This application should be typed or legibly printed in black or blue ink. All sections must be completed, and all questions must be answered. If an area does not apply, write "not applicable (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 applications will be returned unprocessed

2. Facility identifying information

Facility name:	
Doing business as (dba):	Taxonomy code:
National provider identifiers (NPIs) and programs	
NPI:	Program:
NPI:	Program:
NPI:	Program:

Employer identification number (EIN) and tax identification number (TIN). Attach completed W-9 tax form

EIN:	TIN:
Is this TIN shared with any other facility? ☐ Yes ☐ No If yes, complete a separate application for each facility	

Facility addresses

Facility physical address:		City:
State:	ZIP code:	County:
Phone number:	Email:	Website URL:
Facility mailing address:		City:
State:	ZIP code:	County:
Intake phone number:	Intake fax number:	
Facility billing address:		City:
State:	ZIP code:	County:
Phone number:	Fax number:	Email:

Credentialing

Credentialing contact name:		
Credentialing contact phone number:		
Credentialing address:		City:
State:	ZIP code:	Email:
Re-credentialing contact name (if different from contact above):		
Re-credentialing contact phone number:		
Re-credentialing address:		City:
State:	ZIP code:	Email:

Hours of operation

Hours of operation will be displayed in the provider directory

Day	Start time	a.m.	p.m.	End time	a.m.	p.m.	Check if closed on this day
Monday		☐	☐		☐	☐	☐
Tuesday		☐	☐		☐	☐	☐
Wednesday		☐	☐		☐	☐	☐
Thursday		☐	☐		☐	☐	☐
Friday		☐	☐		☐	☐	☐
Saturday		☐	☐		☐	☐	☐
Sunday		☐	☐		☐	☐	☐

3. Facility ownership

If the facility is a wholly owned subsidiary, please provide the name, address, and telephone number of the parent corporation. Include the name and title of the parent corporation's contact person and attach a list of the names, addresses and phone numbers of any other facilities affiliated with the parent corporation and/or owner.

Parent corporation name:			
Address:		City:	
State:	ZIP code:	Parent corporation phone number:	
Contact name:		Title:	Phone number:

4. State license or certificate type (attach current copy)

Licensed by:	
License number:	Expiration date:

5. Insurance information (attach current face sheet)

General liability carrier name:		
Policy number:	Effective date:	Expiration date:
Mailing address:	City:	
State:	ZIP code:	
Coverage per incident:	Coverage aggregate:	
Professional liability carrier name:		
Policy number:	Effective date:	Expiration date:
Mailing address:	City:	
State:	ZIP code:	
Coverage per incident:	Coverage aggregate:	
Explain any surcharges or restrictions to your professional liability coverage (attach additional pages if needed):		
Coverage type: ☐ Occurrence based ☐ Claims made		
If claims made, does the facility have an extended reporting period ("tail coverage")? ☐ Yes ☐ No		

6. Patient visit options (check all that apply)

☐ In-person visits	☐ Telehealth	☐ Telehealth only

7. Gender restrictions

☐ No, there are no practitioners on the facility roster with gender restrictions

☐ Yes, there are practitioners on the facility roster with gender restrictions

Note: if yes, attach a list identifying the practitioners name and gender restrictions (works exclusively with male or female patients)

8. Qualified Medical Interpreter

Is there a Qualified Medical Interpreter (QMI) on staff? ☐ Yes ☐ No

9. Facility type

Check each facility type that applies and the services provided at the facility. Include the facility's registered Medicaid and Medicare numbers.

☐ Free standing hospital	☐ Psychiatric ☐ Substance use disorder
Medicaid number:	Medicare number:
☐ Acute/general hospital	☐ Psychiatric ☐ Substance use disorder
Medicaid number:	Medicare number:
☐ Residential treatment center	☐ Psychiatric ☐ Substance use disorder
Medicaid number:	Medicare number:
☐ Free standing partial program	☐ Psychiatric ☐ Substance use disorder
Medicaid number:	Medicare number:
☐ Free standing intensive outpatient program (IOP)	☐ Psychiatric ☐ Substance use disorder
Medicaid number:	Medicare number:

10. Services offered by facility (check all that apply)

☐ Medical emergency room	☐ Transportation	☐ Senior programs

11. Americans with Disabilities Act (ADA)

Does the facility location meet ADA accessibility requirements? ☐ Yes ☐ No

If yes, check areas below that meet ADA accessibility requirements

☐ Wheelchair accessibility	☐ Exam room	☐ Parking	☐ TTY/TDD assistance
☐ Medical equipment	☐ Table scale	☐ Restroom	☐ Public transportation

12. Facility accreditation

Is the facility accredited? ☐ Yes ☐ No

If yes, check the organization(s) below through which the facility has accreditation, and attach a copy of the current accreditation certificate or survey for each organization selected.

☐ Joint Commission on Accreditation of Healthcare Organizations (JCAHO)		
☐ Commission on Accreditation of Rehabilitation Facilities (CARF)		
☐ Counsel on Accreditation (COA)		
☐ American Osteopathic Association (AOA)		
☐ Accreditation Commission for Health Care/Healthcare Facilities Accreditation Program (ACHC/HFAP)		
☐ Office for Alcohol & Substance Abuse Services (OASIS)		
☐ Det Norske Veritas (DNV)		
☐ National Committee for Quality Assurance (NCQA)		
☐ Utilization Review Accreditation Commission (URAC)		
Date of first/initial accreditation:	Date of next survey:	Date of last survey:

13. Laboratory services

Do you provide direct laboratory services? ☐ Yes ☐ No

If yes, provide the TIN utilized, the Clinical Laboratory Information Act (CLIA) information, and attach a copy of your CLIA certificate or waiver.

TIN:	
CLIA certificate number:	Expiration date:
CLIA waiver certificate number:	Expiration date:

14. Facility contract, clinical, and billing information. A separate application is required for each site.

Contact information

Facility owner or co-founder name:	
License type:	License number:
Phone number:	Email:
Facility chief executive officer name:	
License type:	License number:
Phone number:	Email:
Managed care contact name:	
License type:	License number:
Phone number:	Email:
Clinical or medical director name: Attach the resume/curriculum vitae and job description of the chief clinician/medical director.	
License type:	License number:
Phone number:	Email:
Coordinator of utilization review activities name:	
Phone number:	Email:

Billing information

Select one: ☐ In-house review ☐ Third party review	
License type:	License number:
Phone number:	Email:
Biller or billing company name:	
Select one: ☐ In-house review ☐ Third party review	
Phone number:	Email:

Clinical staff information

Attach a clinical staff roster. Include the license type and professional license number for each staff member.
Languages spoken by facility staff (check all that apply)

☐ Cantonese	☐ Spanish	☐ Russian	☐ Mandarin
☐ Vietnamese	☐ Korean	Other:	

Explanation of benefits (EOB) and electronic remittance advice (ERA)

Paperless ERAs replace paper EOBs. Paper EOBs will be discontinued at the time of enrollment to receive ERAs. Direct electronic data interchange (EDI) trading partners may receive 835 ERAs directly from Blue Shield of California. Authorize a vendor or clearinghouse to receive ERA data to automate your payment posting on your behalf. The information you provide below will certify that the Third Party named is authorized to receive the provider's ERA (also known as the 835). The trading partner is enrolled to receive ERAs via secure file transfer protocol (SFTP) directly from Blue Shield.

Third party vender/clearinghouse name:		
Phone number:	Address:	
City:	State:	ZIP code:
Technical contact name:	Email:	

15. Behavioral health services

For partial hospitalization program (PHP), residential treatment center (RTC), and intensive outpatient program (IOP) levels of care, attach a daily/weekly schedule of programs, facilitated in groups or individually as part of the patient's treatment plan. Provide specific program names and include the name and license type for the person leading the program.

Program description

Has any program in the facility ever been sanctioned by a state or federal program, expelled, or suspended from participation in any health benefit plan? ☐ Yes ☐ No (If yes, attach a detailed explanation)

Services provided by your facility (check all that apply)

☐	Abuse	☐	Addiction (non-chemical)	☐	Adoption
☐	Adults	☐	Anger Management	☐	Anxiety
☐	Applied Behavior Analysis (ABA)	☐	Attention Deficit/Hyperactivity Disorder (ADHD)	☐	Bariatric/Gastric bypass psych evaluation
☐	Behavior modification	☐	Biofeedback	☐	Bipolar
☐	Chronic/Terminal illness	☐	Cognitive Behavioral Therapy (CBT)	☐	Cognitive impairments: including Alzheimer's, dementia, and TBI
☐	Couples/Marriage therapy	☐	Depression	☐	Developmental disabilities
☐	Dialectical Behavior Therapy (DBT)	☐	Dissociative disorders	☐	Domestic violence
☐	Electroconvulsive Therapy (ECT)	☐	End of life issues	☐	Ethnic/Cultural issues
☐	Faith counseling	☐	Family therapy	☐	Fertility issues
☐	Forensics	☐	Gender dysphoria	☐	Gender dysphoria psych evaluation
☐	Gender identity	☐	Gender reassignment surgery psych evaluation	☐	Grief/Bereavement
☐	Group therapy	☐	HIV	☐	Home care/Home visits
☐	Hypnosis	☐	Independent/Qualified medical examiner	☐	Intellectual disabilities
☐	LGBTQIA+	☐	Maternal mental health: including prenatal/postpartum anxiety and/or depression	☐	Medicated assisted treatment for SUD
☐	Medication management	☐	Military lifestyle issues	☐	Mood disorders
☐	Nursing home visits/consultations	☐	Obsessive Compulsive Disorder (OCD)	☐	Organic disorders
☐	Pain management	☐	Panic disorders	☐	Personality disorders
☐	Phobia	☐	Police/Firefighters	☐	Post-traumatic Stress Disorder IPTSD)
☐	Schizophrenia psychosis	☐	Sex offender treatment	☐	Sexual assault
☐	Sexual dysfunction	☐	Sign language capability	☐	Sleep disorders
☐	Solution-focused brief therapy	☐	Somatic disorders	☐	SPRAVATO®
☐	Stress management	☐	Talk therapy	☐	Terminal illness
☐	Transcranial Magnetic Stimulation (TMS)	☐	Transgender	☐	Trauma
☐	Worker's compensation psych evaluation	Other:			

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Medicated assisted treatment (check all that apply)

☐ Buprenorphine	☐ Naltrexone	☐ suboxone	☐ methadone
Other (specify):			

Population served (check all that apply)

☐ Infants/early childhood (0-5)	☐ Children (6-12)	☐ Adolescent (13-17)	☐ Adults (18+)	☐ Seniors

Therapy types offered (check all that apply)

☐ Multi-family (support)	☐ Family	☐ Couples	☐ Individual	☐ Group

Therapy modalities offered (check all that apply)

☐	Applied behavioral analysis (ABA)	☐	Exposure response prevention
☐	Cognitive behavioral therapy (CBT)	☐	Injectable anti-psychotic medication administration
☐	Dialectical behavioral therapy (DBT) techniques	☐	Motivational interviewing
☐	DBT program	☐	Neurofeedback
☐	Eye movement desensitization reprocessing (EMDR)	☐	Telehealth
Other clinical specialties (specify):			
Other language or cultural specialties (specify):			

16. Additional Questions

If you answer yes to any of the following questions, attach a detailed explanation. Failure to answer or provide an explanation may result in a delay in the processing of the application.

Do not use whiteout to correct or change answers. If you need to correct or change an answer, cross out and initial the incorrect answer and provide the correct answer.

1.	Does the business have evidence of professional liability claims history for each subcontractor?	☐ Yes	☐ No
2.	Has the business had disciplinary action taken against any business or professional license held in this or any other state, or surrender of a license in California or any other state?	☐ Yes	☐ No
3.	Does the business have any history of loss or limitation of privileges or disciplinary activity?	☐ Yes	☐ No
4.	Has the business general or professional liability insurance ever been denied, cancelled, non-renewed, or refused upon application for any reason other than by the facility's request?	☐ Yes	☐ No
5.	Has the business, under any current or former name or business entity, ever had licensure to do business in any applicable jurisdiction that has been denied, revoked, reduced, suspended, or not renewed?	☐ Yes	☐ No
6.	Has the business ever been suspended or excluded from receiving payment under Medicare or Medicaid?	☐ Yes	☐ No
7.	Has the business ever had accreditation status reduced, terminated, suspended, or revoked?	☐ Yes	☐ No
8.	Has the business ever been under investigation by any government agency?	☐ Yes	☐ No

Attestation statement

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 any time by sending a request to the Credentialing Department 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:

Signature of authorized agent (stamped signature is not acceptable):

Date signed (omitting date is not acceptable):