Please Note:
The application process is split into different actions. Please send all documentation related to the **contracting** portion of this documentation to:

**Fax to:**
(916)350-8860

**Or email to:**
BSCproviderinfo@blueshieldca.com
Or send via USPS to:
Blue Shield of California
Attn: Provider Information and Enrollment
P. O. Box 629017
El Dorado Hills, CA 95762-9010

Please send all documentation related to the **credentialing** portion of this documentation to:

**Fax to:**
(888)221-1460

**Or email to:**
BSC_Credentialing@blueshieldca.com
Or send via USPS to:
Blue Shield of California
Attn: Credentialing Department
P. O. Box 7168
San Francisco, CA 94105
<table>
<thead>
<tr>
<th><strong>Credentialing Checklist</strong></th>
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<tbody>
<tr>
<td><strong>Allied</strong></td>
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In order for Blue Shield of California to approve your application for Participating Network status, the following items must be sent to Blue Shield’s Credentialing Department:

- **Credentialing Application**
  Completed copy of the attached Credentialing Application.

- **Professional Liability Insurance Certificate**
  Please include a copy of current Professional Liability Insurance Certificate showing the following information:
  - Name of policy holder
  - Name of policy carrier
  - Limits of Liability (1M/3M; 1M/1M for behavioral health providers)
  - Expiration Date

- **Provider License**
  Copy of current license issued by the California State Board of Examiners or National Board Certification for professionals not licensed by the State of California.

- **Curriculum Vitae**
  Please include a copy of the current CV/Resume.

Participating Providers will be assigned an effective date based upon completion of Blue Shield Credentialing, and the receipt and completion of all required documentation. A copy of the executed Agreement (if submitted), including the assigned effective date, will be returned to you when processing is completed.

Please return the attached documentation along with the requested information to the following address:

Blue Shield of California  
Credentialing  
P.O. Box 7168  
San Francisco, CA 94120-7168

If you have questions, please call Provider Information & Enrollment at (800) 258-3091. Thank you.
Credentialing Application

Dear Practitioner/Allied Provider:

This is a requirement for network participation whether you are applying to the network or contracted individually or through a group affiliation. Failure to respond to this notice will potentially lead to non-participation or termination from the Blue Shield of California network. Incomplete applications cannot be processed, therefore please include all of the following documents.

- Credentialing Application – Signed and dated
- Information about any malpractice actions that may have been taken against you, including settlement amounts and/or explanation of any dismissed or pending claims with pertinent dates included (see page 4 of 8).
- Hospital privilege including any additional information as applicable (see page 5 of 8).
- Curriculum vitae – Please explain any work history gaps greater than six months.
- Current Malpractice Liability Insurance Certificate (we cannot accept proof of payment, i.e., check copies or other receipts, as sufficient documentation). Current Blue Shield of California requirements are $1 million per occurrence and $3 million aggregate for all contracted practitioners except behavioral health who require $1/$1 million.
- Copy of your Drug Enforcement Administration (DEA) certification (if applicable).
- Copy of your current license.

If you wish to fax this information to us, the Credentialing Department’s confidential fax number is (888) 221-1460. If you choose not to participate in the Blue Shield of California network, please contact Provider Services at (800) 258-3091.

We look forward to your participation as a Blue Shield of California practitioner, and thank you in advance for providing the necessary information. If you have credentialing questions please call (888) 398-2250.

Sincerely,

The Credentialing Department

Please note: This credentialing process is being conducted under the provisions of California Evidence Code Section 1157 and Health and Safety Code Section 1370. All information submitted or obtained during this process will be used and maintained in accordance with these provisions.
Credentialing application and questionnaire
Please type or carefully print your responses.

1. Practitioner name (as on license): _____________________________

2. Date of birth: _____________________________

3. California Medical license No.: ________________ Expiration date: ________________

4. DEA No.: ________________ Expiration date: ________________

5. Social Security number: ________________

6. Practitioner gender (optional) F M

7. UPIN: ________________

8. Medicare: ________________

9. Medicaid: ________________

10. NPI: ________________

11. Languages spoken: _______________________________________

12. E-mail address: _______________________________________

13. Medical school: Name of school _____________________________

   Address: _______________________________________

   Degree: _______________________________________

   Dates of attendance: _______________________________________

14. Primary office

   • Address: _______________________________________

   • Office phone No.: ( ) _______ – __________

   • Office fax No.: ( ) _______ – __________

   • Name of office manager or credentialing contact person and their contact information: _______________________________________

15. Secondary office (if any)

   • Address: _______________________________________

   • Office phone No.: ( ) _______ – __________

   • Office fax No.: ( ) _______ – __________

   • Name of office manager or credentialing contact person: _______________________________________

16. Mailing information:

   • Address: _______________________________________

   • Contact: _______________________________________

17. Practitioner type: ☐ PCP ☐ Specialist

18. Specialties (please indicate specialties as you practice in your office)

   Primary: _______________________________________

   Board certified ☐ Yes ☐ No Expiration dates: _______________________________________

   Board qualified ☐ Yes ☐ No Expiration dates: _______________________________________

   Secondary: _______________________________________

   Board certified ☐ Yes ☐ No Expiration dates: _______________________________________

   Board qualified ☐ Yes ☐ No Expiration dates: _______________________________________

Name and address of training institutions and training completion dates for each specialty:
________________________________________________________________________
________________________________________________________________________

19. Do you treat patients exclusively within the hospital setting or emergency room, while providing care only as a result of those members being directed to the hospital? ☐ Yes ☐ No

20. Are you currently in the Armed Services ☐ Yes ☐ No

21. Are you currently in the Armed Services Reserves ☐ Yes ☐ No
General information (explain all “yes” answers on a separate sheet)

22. Professional liability
   a) Has any insurer ever denied, cancelled, refused to renew, or imposed restrictions upon your professional liability insurance? ................................................................. Y N
   b) Has there been any claim activity, filed or settled, with respect to your professional practice during the past 5 years? If Yes, provide the following information on a separate sheet of paper: (1) How the matter was resolved, (2) the amount that was paid by you or on your behalf and date of settlement, (3) your role in the matter, (4) the patient outcome, and (5) detailed narrative regarding each incident of malpractice, or complete page 4 of application. ..... Y N

23. Hospital
   a) Have your hospital privileges ever been voluntarily surrendered, expired, or withdrawn during a quality of care investigation? .................................................................................................................................................................. Y N
   b) Have your hospital privileges ever been voluntarily or involuntarily denied, restricted, reduced, or terminated? Y N
   c) Have you ever been the subject of disciplinary action, such as, but not limited to, punitive or disciplinary observation, preceptorship, or sponsorship in a hospital? ............................................................................................................ Y N

24. Governmental
   a) Has any regulatory or licensing agency ever suspended or revoked your license (whether or not such revocation or suspension was stayed), placed you on probation, issued a public or private reprimand with respect to your practice, or otherwise concluded that you engaged in professional misconduct? Y N
   b) Are you currently being investigated by or are you on probation with any governmental agency? Y N
   c) Has any sanction ever been imposed upon you by Medicare or recommended by the Medicare PRO? ......................................................................................................................................................... Y N
   d) Have you ever been expelled or suspended from receiving payment under Medicare, Medi-Cal, or TRICARE/CHAMPUS? .................................................................................................................................................. Y N
   e) Have you ever been convicted of a felony or misdemeanor (including those deferred, set aside, dismissed, expunged, or issued a stay of execution)? ............................................................................................................. Y N

25. Other
   a) Have you ever been expelled from or disciplined by a medical organization for professional competency reasons? ................................................................................................................................................. Y N
   b) Has your contract with an insurer, healthcare service plan, or any similar entity ever been terminated? ......................... Y N
   c) Do you have any health problems that might affect your practice of medicine? ................................................................. Y N
   d) Do you currently use illegal drugs? .............................................................................................................................................. Y N
   e) Are there any reasons you would not be able to perform all the services required by your agreement with and the bylaws of Blue Shield of California, with or without reasonable accommodation, according to accepted standards of professional performance and without posing a direct threat to the safety of patients? ................................................................. Y N

26. Work history: Complete your most recent 5-year work history below. Please explain all gaps 6 months or greater in your work history.
   a) Mo/Yr: From: To: Position: 
      Employer: Address: City State
   b) Mo/Yr: From: To: Position: 
      Employer: Address: City State
   c) Mo/Yr: From: To: Position: 
      Employer: Address: City State
   d) Mo/Yr: From: To: Position: 
      Employer: Address: City State
Malpractice Claim Form

This is your opportunity to explain in your own words what occurred. Your response will be kept strictly confidential and will be reviewed only by Blue Shield Of California’s credentialing department and a committee of your peers.

Photocopy and complete this form including all relevant clinical information for each claim filed or settled in the past five years. If more space is needed on each report, continue information on your letterhead. Please write legibly.

1. Patient’s initials or case I.D: ________________________________

2. Date of Incident: __________

3. Relationship to patient (e.g., attending physician, consultant, primary surgeon, assistant surgeon, etc.):

4. Specific allegation: ________________________________________

5. Status:
   □ Lawsuit/arbitration/claim currently pending
   □ Withdrawn/dropped/date: __________________________
   □ Lawsuit/arbitration/judgment
      □ Dismissed/date: __________________________
      □ Settlement/date: __________________________
         Total amount paid: __________________________
         Amount paid on your behalf ____________________
   □ Lawsuit is related to a Medical Board accusation/action Date: ________________
   □ Lawsuit is related to a cancellation of liability insurance Date: ________________

6. Condition and diagnosis at time of incident:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

7. Dates and clinical description of professional services rendered:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

8. Condition of patient subsequent to professional services, (dates of follow-up visits and outcome of incident) if known:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

9. Comments (including any additional education or changes to practice):

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
Hospital Privileges Form

Please note: Completing this form is required. List the name, type of privileges, and address of hospitals where you have medical staff privileges. Temporary privileges are not acceptable. If you do not maintain hospital privileges see alternative requirements below.

<table>
<thead>
<tr>
<th>Hospital name</th>
<th>Type of privileges</th>
<th>Hospital address</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(Active, provisional, courtesy, attending)</td>
<td></td>
</tr>
</tbody>
</table>

If you do not maintain hospital privileges Blue Shield of California requires that you meet one of the following alternative methods to ensure continuity of care for inpatient admissions. Attach the additional information to your application.

1.☐ Having in place a formalized referral process with at least one other physician who has a contract with Blue Shield of California. The other physician must be identified and provide Blue Shield with their written agreement to provide coverage.

OR

2.☐ Being a member of a medical group that has documentation defining the medical group inpatient coverage arrangements, ie., hospitalists. Please provide copy of documentation.

OR

3.☐ Explain in writing how your practice is set up to care for patients who need immediate inpatient care. Specifically, identify your policies for transfer and continuity of care, ie., notifying a primary care physician and/or other specialists regarding admitting diagnosis, inpatient care, and plans for discharge follow-up care.
HIV/AIDS Specialist Privileges Form

In order to comply with state regulations (AB2168), we need to identify appropriately qualified specialists within our network who meet the definition of an HIV/AIDS Specialist. Please review and check the appropriate box below. This information will be used for internal referral procedures.

☐ No, thank you, I do not wish to be designated an HIV specialist.

Yes, I do wish to be designated an HIV specialist and meet the following criteria:

☐ I am a member of the American Academy of HIV Medicine.

OR

☐ I am board-certified in Infectious Disease and in the past 12 months have clinically managed at least 25 HIV patients and completed 15 hours of category 1 CME in HIV medicine, 5 hours of which must be related to anti-retroviral therapy;

OR

☐ In the past 24 months, I have provided clinical management to 20 HIV patients and in the past 12 months have completed board certification in Infectious Disease;

OR

☐ In the past 24 months, I have provided clinical management to 20 HIV patients and in the past 12 months have completed 30 hours of category 1 CME in HIV medicine;

OR

☐ In the past 24 months, I have clinically managed at least 20 HIV patients and in the past 12 months have completed 15 hours of category 1 CME in HIV medicine and successfully completed the HIV Medicine Competency Maintenance Examination administered by the American Academy of HIV Medicine.
Attestation/release of information

I consent to the communication of information and documents between Blue Shield of California (BSC) or its agents and other business entities, medical staffs, training programs, medical societies, professional associations, professional liability insurance companies, and licensing authorities in jurisdictions in which I have trained, resided, or practiced, for the evaluation of professional training, experience, character, conduct, and judgment. In this regard, the utmost care shall be taken to safeguard the privacy of patients and the confidentiality of patient records.

In the event that credentialing information obtained from other sources varies substantially from that which I have provided, I will be given the opportunity to review and explain the discrepancies.

I acknowledge that there shall be no monetary liability on the part of and no cause of action for damages shall rise against any representative of Blue Shield or its agents for their acts performed in connection with evaluating physician/practitioner applications, credentials, and qualifications. I acknowledge that there shall be no monetary liability on the part of and no cause of action for damages shall rise against any or all individuals and organizations providing information to Blue Shield or its agents concerning professional competence, ethics, character, and other qualifications for participation. I have the right to review the information submitted in support of the credentialing/recredentialing application, in accordance with Blue Shield guidelines.

I understand and agree that I as an applicant have the burden of producing adequate information for proper evaluation of my professional competence, character, ethics, and other qualifications, and for resolving any doubt about such qualifications.

During such time as this application is being processed, I agree to immediately update the application and any documentation submitted and/or included with this application should be there any change in the information provided which may affect the application or its outcome.

I hereby affirm that the information submitted in this application is true and correct to the best of my knowledge and is furnished in good faith. I understand that willful and substantial omissions or misrepresentations may result in denial of my application or termination of my Blue Shield membership.

Reminder: Be sure you return and attach all of the following to this form:

☐ Enclose a copy of your current malpractice liability certificate. (Proof of payment, i.e. Check copies or other receipts are not acceptable forms of documentation. You must provide copies of your certificate(s) showing at least $1 million/$3 million or $1 million/$1 million for behavioral health.)

☐ Explanation of all malpractice issues dismissed, pending, or settled, including dates (use malpractice claim form).

☐ Curriculum vitae – enclose a copy of your current CV. (Please explain any gaps 6 months or greater in work history.)

☐ A copy of your current DEA registration. (Proof of payment, i.e., check copies or other receipts are not acceptable forms of documentation. You must provide copies of your certificate.)

☐ A copy of your current license.

☐ Attestation of hospital privileges or additional information as applicable. (Use hospital privileges form.)
Practitioners' Rights

A practitioner has the right to review information obtained by Blue Shield of California for the purpose of evaluating his/her credentialing or recredentialing application. This includes non-privileged information obtained from any outside source (e.g., malpractice insurance carriers, state licensing boards or the National Practitioner Data Bank), but does not extend to review of information, references or recommendations protected by law from disclosure. A practitioner has the right to request his/her status within the BSC network. Upon written request, the Blue Shield of California Credentialing Department will provide details of his/her current status in the credentialing or recredentialing process.

• Right of Review: A practitioner may request to review such information at any time by sending a written request via letter or fax to the Credentialing Department Manager/Supervisor. The Manager/Supervisor of Credentialing will notify the practitioner within 72 hours of the date and time when such information will be available for review at Blue Shield of California’s Credentialing Department.

• Notification of Discrepancy: Practitioners will be notified in writing, via letter or fax, when information obtained by primary sources varies substantially from information provided on the practitioner’s application. Examples of information at substantial variance include reports of a practitioner’s malpractice claim history, actions taken against a practitioner’s license/certificate, suspension or termination of hospital privileges or board certification expiration when one or more of these examples have not been self-reported by the practitioner on his/her application form. Practitioners will be notified of the discrepancy at the time of primary source verification. Sources will not be revealed if information obtained is not intended for verification of credentialing elements or is protected from disclosure by law.

• Correction of Erroneous Information: If a practitioner believes erroneous information has been supplied to BSC by primary sources, the practitioner may correct such information by submitting written notification to the Credentialing Department. Practitioners must submit written notice via letter or fax, along with a detailed explanation, to the Manager/Supervisor of Credentialing. Notification to Blue Shield of California must occur within 48 hours of BSC’s notification to the practitioner of a discrepancy as provided in Section b.), above, or within 24 hours of a practitioner’s review of his/her credentialing file as provided in Section a.), above.

Upon receipt of notification from the practitioner, BSC will re-verify the primary source information in dispute. If the primary source information has changed, correction will be made immediately to the practitioner’s credentialing file. The practitioner will be notified in writing, via letter or fax, that the correction has been made to his/her file. If upon re-review the primary source information remains inconsistent with the practitioner’s notification, the Credentialing Department will notify the practitioner via letter or fax. The practitioner may then provide proof of correction by the primary source body to Blue Shield of California’s Credentialing Department via letter or fax within 10 business days. The Credentialing Department will re-verify primary source information if such documentation is provided.

If after 10 business days the primary source information remains in dispute, the practitioner will be subject to action, up to and including administrative denial/termination.

Practitioners should submit correspondence regarding practitioner rights to:

Blue Shield of California
Credentialing Department
Attn: Credentialing Manager
50 Beale Street, 21st Floor
San Francisco, CA 94105
Fax: 888-221-1460