Individual Practitioner Application Form (RA-01)

The data provided on this form or an 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. Blue Shield and/or Blue Shield Promise will confirm eligibility of the applicant for claims submission, using the contact information provided.

Instructions

Identify the 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), 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* (*ICF-01*). 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, contact Provider Information and Enrollment via email at BSCProviderinfo@blueshieldca.com.

In accordance with regulatory requirements, Blue Shield and Blue Shield Promise reports and publishes a maximum number of in-person locations for practitioners:

Primary Care Physicians

One practitioner may not be listed as a primary care physician (PCP) in more than six (6) in-person service location addresses across the entire network. This requirement applies even if the practitioner is listed as a PCP on rosters for multiple, separately contracted IPA/medical groups. The aggregated total for providing in-person services as a PCP must not exceed six (6) service locations in the Blue Shield and/or Blue Shield Promise provider directories.

Physician Specialists

One physician specialist may not be listed as a specialist in more than ten (10) in-person service location addresses across the entire network. This requirement applies even if the practitioner is listed as a specialist on rosters for multiple, separately contracted IPA/medical groups. The aggregated total for providing in-person services as a specialist must not exceed ten (10) service locations in the Blue Shield and/or Blue Shield Promise provider directories.

The above limitation requirements only apply to in-person service locations for each PCP or specialist practitioner. No limits apply to locations where only telehealth or virtual care services are provided. If the practitioner provides both telehealth and in-person services to Blue Shield and/or Blue Shield Promise members at the location, it will be counted as an in-person service location.

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By submitting this form, the applicant certifies that all information included on this form is true, accurate and complete. Any false statements, concealment of material fact, or 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.

The practitioner email entered into this form will be tied to your Blue Shield provider portal account notifications and used for account-specific outreach. This email address should not be a billing or provider group email address but your individual business email address.

Please type or print information in all fields.

Individual licensed practitioner information

Licensed practitioners first name, middle name, and last name:		
National Provider Identifier (NPI):	Social Security Number (SSN):	
Date of birth:	Gender: ☐ Male ☐ Female	
Blue Shield does not discriminate or base its decisions on the applicants race, ethnicity, or language.		
Race:	Ethnicity:	
Language(s) spoken:		
Practice website URL:		
Primary specialty/type of service:		
Secondary specialty/type of service:		
License/certification/permit issuing body:		
License/certification number (attach document copy):		
EIN/TIN (attach pre-printed tax document W-9):		
Hospital affiliation (full hospital name):	Hospital based: ☐ yes ☐ no	
Supervising physician name (if applicable):	Supervising physician NPI:	

Paperless remittance advice (replaces paper explanation of benefits)

Direct electronic data interchange (EDI) trading partners may receive 835 electronic remittance advices (ERAs) directly from Blue Shield and/or Blue Shield Promise.

Authorize a vendor/clearinghouse to receive ERA data to automate your payment posting on your behalf.

This information will certify that the Third Party vendor/clearinghouse named below is authorized to receive ERAs, also known as the 835, on behalf of the provider. 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 on behalf of the provider. The trading partner is enrolled to receive ERA via secure file transfer protocol (SFTP) directly from Blue Shield and/or Blue Shield Promise.

Name:			
Address:	City:	State:	ZIP code:
Phone number:	Fax number:	Email address:	
Name of technical contact:			

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Service and billing information

Service Location

For additional locations, use this page as a template.

Practice address (see page 1 for special instructions):		
City:	State:	Zip Code:
Appointment phone number:	Fax number:	
After-hours phone number (if applicable):	**Business email** address:	
Wheelchair access: ☐ Yes ☐ No		

Office hours of operation. Indicate start and end times for each day. If the office is closed, mark N/A													
Sunday		Monday		Tuesday		Wednesday		Thursday		Friday		Saturday	
Start	end	Start	end	Start	end	Start	End	Start	End	Start	End	Start	End

Qualified Medical Interpreter (QMI): ☐ Cantonese ☐ Korean ☐ Mandarin ☐ Russian ☐ Spanish ☐ Vietnamese	
Additional language(s) spoken (non-QMI):	

Patient visit options: ☐ telehealth ☐ in-person	Gender limitations: ☐ Male only ☐ Female only ☐ None	
Children's Health Insurance Program (CHIP): ☐ CHIP targeted low income children ☐ CHIP Medi-Cal Access Program		
Patient acceptance: ☐ Current patients only ☐ New and existing patients	Lowest age:	Highest age:
Handicap accessibility (check all that apply): ☐ Exam room ☐ Exterior handicap accessible ☐ Internal handicap accessible ☐ Medical equipment ☐ Table scale ☐ Parking ☐ Wheelchairs available		

Billing Information

Address (if different from service location):		
City:	State:	Zip Code:
Phone number:	Fax number:	