Provider Group/Facility Application Form (RA-02)

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 a provider group or facility 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 provider group or facility requiring a billing record and complete all fields with the group or facility information. One application per service location is required**.**

Complete page three of this application with all required data elements for professional practitioners at this location. For additional practitioners, use page three 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

This request will not be initiated until all 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 to process the application.

- 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.
- 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* (*ICF-02*).

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 as follows:

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.

Provider Group/Facility Application (RA-02)

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 provider group/facility email entered into this form will be tied to your Blue Shield provider portal account notifications and used for account-specific outreach.**

Please type or print information in all fields.

Provider Group/Facility information

Provider name/Doing business as (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 (check all that apply): ☐ Telehealth ☐ in-person	Website URL:

Provider group/facility location information. Use a separate application for additional locations.

Practice location street address:		
City:	State:	Zip Code:
Location appointment phone number:	Location fax number:	
After hours phone number (if applicable):	Wheelchair accessible: ☐ Yes ☐ No	
Provider group/facility email address:		

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):
Children's Health Insurance Program (CHIP): ☐ CHIP targeted low income children ☐ CHIP Medi-Cal Access Program
Handicap accessibility (check all that apply): ☐ Exam room ☐ Medical equipment ☐ Table scale ☐ Exterior handicap accessible ☐ Internal handicap accessible ☐ Parking ☐ Wheelchairs available

Billing information

Address (if different from above service location):		
City:	State:	Zip code:
Billing phone number:	Billing fax number:	

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:			

Provider Group/Facility Application (RA-02), cont'd

By submitting this form the 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 service location indicated on page two. Additional practitioners for that service location can be added using a copy of the following template.

Roster Practitioner 1

Licensed practitioner name:	Title:	Degree:
License number:	NPI:	
License issuing body:		
Supervising physician's name (if applicable):	Supervising Physician's NPI:	
Hospital affiliation name(s) (for MD or DO):	Hospital-based: ☐ Yes ☐ No	
Practitioner language(s) spoken:	Practitioner ethnicity:	
Patient acceptance: ☐ Current patients only ☐ New and existing patients		
Gender limitations: ☐ Male only ☐ Female only ☐ None	Lowest age: Highest age:	

Roster Practitioner 2

Licensed practitioner name:	Title:	Degree:
License number:	NPI:	
License issuing body:		
Supervising physician's name (if applicable):	Supervising Physician's NPI:	
Hospital affiliation name(s) (for MD or DO):	Hospital-based: ☐ Yes ☐ No	
Practitioner language(s) spoken:	Practitioner ethnicity:	
Patient acceptance: ☐ Current patients only ☐ New and existing patients		
Gender limitations: ☐ Male only ☐ Female only ☐ None	Lowest age: Highest age:	

Roster Practitioner 3

Licensed practitioner name:	Title:	Degree:
License number:	NPI:	
License issuing body:		
Supervising physician's name (if applicable):	Supervising Physician's NPI:	
Hospital affiliation name(s) (for MD or DO):	Hospital-based: ☐ Yes ☐ No	
Practitioner language(s) spoken:	Practitioner ethnicity:	
Patient acceptance: ☐ Current patients only ☐ New and existing patients		
Gender limitations: ☐ Male only ☐ Female only ☐ None	Lowest age: Highest age:	

Roster Practitioner 4

Licensed practitioner name:	Title:	Degree:
License number:	NPI:	
License issuing body:		
Supervising physician's name (if applicable):	Supervising Physician's NPI:	
Hospital affiliation name(s) (for MD or DO):	Hospital-based: ☐ Yes ☐ No	
Practitioner language(s) spoken:	Practitioner ethnicity:	
Patient acceptance: ☐ Current patients only ☐ New and existing patients		
Gender limitations: ☐ Male only ☐ Female only ☐ None	Lowest age: Highest age:	