



Healthy Blue



Health Care Delivery Organization and Ancillary Application

Please submit all applicable documents from the list below with your completed and signed application. Failure to submit a complete application and all applicable documents will result in the application being returned and will prohibit Healthy Blue from completing the credentialing and/or contracting process.

Note: Submission of a completed application does not guarantee approval as a participating provider as additional information and/or documentation may be required by Healthy Blue.

Required attachments:

- Copy of all federal, state and/or local licenses required to operate as a health care facility (by location)
- Copy of Accreditation certificate/letters OR
 - Copy of most recent CMS or state survey (with deficiencies) including cover letter from CMS or state agency stating facility is in substantial compliance or Corrective Action Plan if deficiencies were cited
- Copy of Medicaid and Medicare Certification(s) or certificate numbers on the application
- W-9
- Current copy of professional liability insurance and general liability insurance (must indicate coverage limits, policy number, effective date and expiration date)
- Proof of established Quality Improvement Program
- Current copy of pharmacy license in state where contracting (for ambulatory and home infusion therapy providers)
- *Clinical Laboratory Improvement Act* certificate(s) for each location (for dialysis and laboratory providers)

As requested by our Network Provider Solutions, additional paperwork or addendums to this application may need to be completed.

<https://provider.healthybluene.com>

Healthy Blue is the trade name of Community Care Health Plan of Nebraska, Inc., an independent licensee of the Blue Cross and Blue Shield Association.

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Instructions: Complete the following pages and return to Healthy Blue with the required attachments.

Provider type		
<input type="checkbox"/> Ambulatory surgery center	<input type="checkbox"/> Home health agency	<input type="checkbox"/> Outpatient rehab center/hospital
<input type="checkbox"/> Birthing center	<input type="checkbox"/> Home infusion therapy	<input type="checkbox"/> Portable X-ray supplier
<input type="checkbox"/> Clinical laboratories	<input type="checkbox"/> Hospice facility	<input type="checkbox"/> Rural health clinic (RHC)
<input type="checkbox"/> Dialysis center/ESRD	<input type="checkbox"/> Hospital	<input type="checkbox"/> Skilled nursing facility
<input type="checkbox"/> Federally qualified health center (FQHC)	<input type="checkbox"/> Inpatient rehab hospital	
Behavioral health		
<input type="checkbox"/> Ambulatory detox	<input type="checkbox"/> Partial hospitalization — psychiatric	
<input type="checkbox"/> Community mental health center	<input type="checkbox"/> Partial hospitalization — substance abuse	
<input type="checkbox"/> Crisis stabilization unit	<input type="checkbox"/> Psychiatric inpatient rehabilitation	
<input type="checkbox"/> Hospital — inpatient detox	<input type="checkbox"/> Psychiatric residential treatment facility	
<input type="checkbox"/> Hospital — psychiatric	<input type="checkbox"/> Residential treatment center — substance abuse	
<input type="checkbox"/> Intensive outpatient — psychiatric	<input type="checkbox"/> Substance abuse — inpatient rehabilitation	
<input type="checkbox"/> Intensive outpatient — substance abuse	<input type="checkbox"/> Substance abuse clinic — outpatient services	
<input type="checkbox"/> Mental health clinic — outpatient services		
<input type="checkbox"/> Methadone maintenance clinic		
Provider identification		
Legal business name:		
Doing business as (if applicable):		
Primary contact person:		
Title:		
Email:		
Primary contact address:		
City:	State:	ZIP code:
Phone:	Fax:	
Credentialing information		
Credentialing contact name:		
Title:		
Email:		
Credentialing address:		
City:	State:	ZIP code:
Phone:	Fax:	
Primary office/service address		
Does the facility have multiple locations? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, attach a separate sheet for other locations.)		
Address line 1:		
Address line 2:		
City:	State:	ZIP code:
County:		
Phone:	Fax:	
Primary contact:		
Primary contact email:		
Phone:	Website:	
Administrator (full name):		
Medicaid #:	Medicare #:	
TIN/EIN:	NPI #:	

Taxonomy code(s):			
Does provider bill from this address? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Does this office meet ADA accessibility requirements? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Check all that apply:			
Handicap accessible:	<input type="checkbox"/> Building <input type="checkbox"/> Parking <input type="checkbox"/> Restroom		
Services for disabled:	<input type="checkbox"/> TTY <input type="checkbox"/> American Sign Language <input type="checkbox"/> Mental/physical impairment		
Accessible by public transportation:	<input type="checkbox"/> Bus <input type="checkbox"/> Subway <input type="checkbox"/> Regional train		
Billing information			
Contact name (billing contact):			
Title:			
Address line 1:			
Address line 2:			
City:	State:	ZIP code:	
Phone:		Fax:	
Email:			
Website:			
Preferred method of communication: <input type="checkbox"/> Email <input type="checkbox"/> Fax <input type="checkbox"/> Mail			
Licensure/operating certificate			
State:	Date of license:	License number:	Expiration date:
State:	Date of license:	License number:	Expiration date:
CLIA certificate #:			
Accreditation/certification (Attach a copy of current accreditation certificate or survey.)			
A.			
<input type="checkbox"/> AAAASF	<input type="checkbox"/> CABC	<input type="checkbox"/> COLA	<input type="checkbox"/> TJC
<input type="checkbox"/> AAAHC	<input type="checkbox"/> CAHC	<input type="checkbox"/> CTEAM	<input type="checkbox"/> AIUM
<input type="checkbox"/> AAPSF	<input type="checkbox"/> CCAC	<input type="checkbox"/> DNV/NIAHO	<input type="checkbox"/> FDA CERT
<input type="checkbox"/> ACHC	<input type="checkbox"/> CHAP	<input type="checkbox"/> HFAP	<input type="checkbox"/> _____
<input type="checkbox"/> ACR	<input type="checkbox"/> CIHQ	<input type="checkbox"/> HQAA	<input type="checkbox"/> Not accredited (if not accredited, please complete Section B below)
<input type="checkbox"/> BOC INTL	<input type="checkbox"/> COA	<input type="checkbox"/> IMQ	
Date of initial accreditation:		Date of next survey:	
Date of last survey:			

B.							
Has provider had an onsite survey by CMS or state? <input type="checkbox"/> Yes <input type="checkbox"/> No*							
Date of last recertification/annual state survey program review report:							
* If no, successful completion of an onsite visit is required to complete credentialing. You will be contacted to schedule the visit.							
Non-accredited providers must provide a copy of their most recent government agency survey (may not be older than 36 months) along with the Corrective Action Plan (if deficiencies were cited) or attach the letter from the government agency stating facility is in substantial compliance with most recent survey standards. Failure to provide documentation or complete the onsite survey may delay your ability to become a participating provider.							
General and professional liability insurance							
General liability coverage (Attach copy of current insurance face sheet/declaration page.)							
Carrier name:							
Policy #:							
Effective date:				Expiration date:			
Coverage per incident: \$				Coverage aggregate: \$			
Professional liability insurance							
Carrier name:							
Policy #:							
Effective date:				Expiration date:			
Coverage per incident: \$				Coverage aggregate: \$			
Provider directory							
The following information will be used for your provider directory listing.							
Office hours							
	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Open:							
Close:							
About the facility							
1. Does the facility have experiences and skills in treating persons with:							
A. Physical disabilities?		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A					
B. Chronic illness?		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A					
C. HIV/AIDS?		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A					
D. Serious mental illness?		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A					
2. Do you have experience and skills in treating individuals who are:							
1. Homeless?		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A					
2. Deaf or hard of hearing?		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A					
3. Blind or visually impaired?		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A					
What languages (other than English) are spoken by you/facility staff fluently enough to treat patients who only speak that language?							

Disclosure questions	
<ul style="list-style-type: none"> • If you answer yes to any of the following questions, attach a detailed explanation. • If any question does not apply, please answer no. • Failure to answer or provide an explanation may result in a delay in processing the application. • Do not use whiteout to correct/change answers; if you need to correct/change an answer, cross out the incorrect answer, initial it and then mark the correct answer. 	
1. Does the business have evidence of:	
A. Professional liability claims history for each subcontractor?	<input type="checkbox"/> Yes <input type="checkbox"/> No
B. Disciplinary action taken against any business or professional license held in this or any other state or surrender of a license in this or any state?	<input type="checkbox"/> Yes <input type="checkbox"/> No
C. Any history of loss or limitation of privileges or disciplinary activity?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. 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?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	
3. Has the business, under any current or former name or business entity, ever:	
A. Had licensure to do business in any applicable jurisdiction ever been denied, revoked, reduced, suspended or not renewed?	<input type="checkbox"/> Yes <input type="checkbox"/> No
B. Been suspended or excluded from receiving payment under Medicare or Medicaid?	<input type="checkbox"/> Yes <input type="checkbox"/> No
C. Had accreditation status reduced, terminated, suspended or revoked?	<input type="checkbox"/> Yes <input type="checkbox"/> No
D. Been under investigation by any government agency?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Is the business' professional liability insurance provided through a self-insurance trust or program? **	
<input type="checkbox"/> Yes <input type="checkbox"/> No	
<p>** If yes, an officer of the company (e.g., president, vice president, chief financial officer or chief operating officer) must sign the following attestation.</p> <p>On behalf of the applicant, I represent and warrant the following with respect to the self-insurance program maintained by the applicant or which provides professional liability insurance for the applicant:</p> <ol style="list-style-type: none"> 1. The self-insurance program is adequately funded to provide the minimum required limits of liability as required by plan. 2. The self-insurance program has an actuarially validated reserve adequate for incurred claims, for incurred but not reported claims and future claims based on past experience. 3. The self-insurance program has a designated third-party administrator or other appropriately licensed claims professional or attorney serving the program. 4. The self-insurance program has a designated medical malpractice defense firm or more than one designated medical malpractice defense firm. 5. The self-insurance program maintains excess insurance/reinsurance above the self-funded level if the self-insured level alone is insufficient to meet required limits of the plan. 6. The self-insurance program maintains evidence of a surety bond or letter of credit as collateral to the self-insured limit or a captive, self-management of a large retention through a trust. 7. The self-insurance program maintains a total value of the program that, at a minimum, meets the required limit of liability as set forth by plan. 8. I have confirmed the foregoing with my auditor or the actuary for the self-insurance fund. 	
Attestation signature:	Date:
Printed name:	Title:
Note: Healthy Blue reserves the right to request documentation from the applicant to confirm the information disclosed in this attestation.	

Attestation	
<p>I, the undersigned authorized agent, hereby attest that the information submitted in, or in support of, this application is true, accurate and complete to the best of my knowledge and belief and is furnished in good faith. I understand that significant omissions or misrepresentations may result in denial of the application and/or participating agreement.</p>	
<p>A photocopy of this document shall be as effective as the original.</p>	
Preparer's name:	Title:
Signature:	Date: