Medication-Assisted Treatment Facility Recredentialing Application

Instructions: All providers should complete Sections A and B. Complete the portions of the sections that apply to your organization by attesting to the program requirements outlined in this form. All providers are required to attest to the appropriate corresponding program criteria attached. Recredentialing is conducted every three years and unless you are notified, participation will remain effective with no gaps.

If you have any questions, please call 800-756-2749 or send an email to prov.net@bcbsnd.com.

Section A: Program Type *(Place a check next to ALL correct classifications)*

☐ Opioid Treatment Program
☐ Office-Based Opioid Treatment

Section B: Provider Information

Facility Information *(Please complete a separate application for each practicing location)*

Name of Facility		Federal TIN	
NPI		Effective Date of Group	
Physical Street Address Street City State Zip		Billing/Mailing Address (*If different from physical address*) Street City State Zip	
Patient Appointment Phone #	Office Fax #	Billing Telephone #	Billing Fax #
Business Office Contact Name and Phone #		Business Office Contact Email	
Name and Title of Chief Administrator			
Facility accepts *(Check all that apply):* ☐ Credit Card ☐ Debit Card ☐ Neither			

Malpractice/Liability Insurance

Attach the malpractice insurance face sheet and evidence (e.g. roster, letter, fax) that clearly states the name of provider being credentialed and covered under your insurance policy. The face sheet must also contain the name of insurance company, from and through dates, policy number and occurrence/aggregate coverage amounts.

Did you attach a copy of malpractice insurance face sheet? ☐ Yes ☐ No

Opioid Treatment Program Current License / Certification *(Attach a current copy licenses and certificates)*

	State	Current State License, Certification Number	Original Issue Date (*MM/DD/YYYY*)	Expiration Date (*MM/DD/YYYY*)
State License (Nonprovisional)				
SAMHSA Opioid Treatment Program Certification				
DEA				
Medicaid				

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Malpractice/Liability Insurance *(Continued)*

Release and Attestation

The undersigned is authorized to act on behalf of the institution (Entity), and certifies that all information submitted on this application and all attachments hereto are correct, true and complete to the best of my knowledge.

The Entity consents to complete disclosure of and authorization to make available to Blue Cross Blue Shield of North Dakota (BCBSND), its affiliates or any of their agents, all relevant information pertaining to and deemed necessary and appropriate in the investigation and processing of this application, including but not limited to, information obtained through a third party such as an insurance company, licensing authority, accrediting agency or governmental agency.

The Entity releases and discharges BCBSND, its affiliates and their representatives, credentials committees, administrators, governing bodies, agents, employees and all other persons or entities supplying information to them, from liability or claims of any kind or character in any way arising out of inquiries or disclosures made in good faith in connection with this application.

The Entity agrees to update this application while it is being processed should there be any change in the information provided regarding the Entity that could affect the application or its outcome. A photocopy of this document shall be as effective as the original.

Name (*Print or Type*)	Title
Signature	Date (*MM/DD/YYYY*)

SUBMIT INSTRUCTIONS

If you are having difficulty submitting the form once completed, please send using one of the following methods:

- Email (Please follow these steps):
  - Click on 'File' at the top of your screen
  - Click on 'Save As'
  - Save the completed form on your computer
  - Attach the completed form to an email and send to providerforms@bcbsnd.com
- Fax: 701-282-1910
- Mail: 4510 13th Ave S
  Fargo, ND 58121

Please double check that the application is complete.

SUBMIT FORM

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