Home Infusion Therapy Facility Check List and Recredentialing Application

Please complete every section of the attached form. The following list may be used as a reference to assist you with the application. Recredentialing is conducted every three years and unless you are notified, participation will remain effective with no gaps.

- ☐ **Home Infusion Therapy Facility Information**
- ☐ **Malpractice/Liability Insurance:** Attach the malpractice insurance certificate or face sheet and evidence on letterhead (e.g. roster, letter, or fax) which clearly states that the provider, facility or institution is covered by the insurance policy. The face sheet will also need to contain the name of insurance company, from and through dates, policy number, and occurrence/aggregate amounts.
- ☐ **Requirements:** Medicare Certification or Medicare Participation. Notify BCBSND of any changes to your Medicare status as it may affect your credentialing and/or continued participation.

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

Home Infusion Therapy Facility Information *(Please complete a separate application for each location)*

Name of Facility Medicare Certification # or Medicare Participation #		Federal TIN Taxonomy Code	
Physical Street Address (Street, City, State, Zip) Street City State Zip		Billing/Mailing Address (Street, City, State, Zip) (*If different from physical address*) Street City State Zip	
Office Phone #	Office Fax #	Billing Phone #	Billing Fax #
Office Staff Foreign Languages	☐ Speak ☐ Read ☐ Write ☐ N/A		
Business Office Contact Name		Business Office Email Address	
NPI Number	Date Business Opened	Name and Title of Chief Administrator	

Type of Facility/Ownership

- ☐ Government (Federal, State, County, City)
- ☐ Private Non-Profit
- ☐ Private For Profit
- ☐ Other:

Organizational Structure

- ☐ Corporation
- ☐ Partnership
- ☐ Single Owner
- ☐ Public Agency
- ☐ Group Practice Assoc.
- ☐ Professional Corporation

Malpractice/Liability Insurance

Attach copy of malpractice face sheet.

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Release and Attestation

The undersigned is authorized to act on behalf of the institution/facility (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

SUBMIT FORM