Recredentialing Application
Institution/Facility

Recredentialing is conducted every three years and unless you are notified, your participation will remain effective with no gaps.

Facility/Agency Type
Place a check next to ALL correct classifications

- ☐ Ambulatory Surgery Center
- ☐ Diabetes Prevention Program
- ☐ Dialysis/Kidney Center
- ☐ Free Standing Radiology/Portable X-Ray Supplier
- ☐ General Hospital (Short Term)
- ☐ General Hospital (Long Term)
- ☐ Hearing Aid Supplier
- ☐ Home Health Agency
- ☐ Hospice
- ☐ Laboratory (Independent or Hospital-Based)
- ☐ Rehabilitation Facility
- ☐ Skilled Nursing Facility
- ☐ Swing Bed
- ☐ Urgent Care
- ☐ Other (Description):

Institution or Facility Information
Please complete a separate application for each practicing location

Name of Facility: NPI: Taxonomy Code:	Federal TIN: Effective Date of Group: Display in Directory ☐ Yes ☐ No
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

Patient Appointment Phone #: ( )	Office Fax #: ( )	Billing Phone #: ( )	Billing Fax #: ( )

Office Staff Foreign Languages: ☐ Speak ☐ Read ☐ Write ☐ N/A	Business Office Contact Name: Business Office Email Address:
Is the Facility Certified as a National Disaster Medical System (NDMS)? ☐ Yes ☐ No	Name and Title of Chief Administrator:
Total Licensed Bed Capacity:	Facility Accepts (Check All That Apply): ☐ Credit Card ☐ Debit Card ☐ Neither

Trauma level

- ☐ I – All Complex Injuries
- ☐ II – Severe Trauma
- ☐ III – Common Trauma w/o specialized care
- ☐ IV – Routine Care
- ☐ V – Routine Care – May not be 24/7
- ☐ 0 – No Trauma Care

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Current License/Certificate

Attach A Current Copy Of All Licenses And Certificates That Apply

Issued By	Current State License Or Certification #	Original Issue Date	Expiration Date
State			
Medicare Certification #			
Medicaid			
The Joint Commission			
CARF *(Commission On Accreditation of Rehabilitation Facilities)*			
AAAASF *(American Association for Accreditation of Ambulatory Surgery Facilities)*			
AAAHC *(Accreditation Assoc. for Ambulatory Health Care, Inc.)*			
Other			

Malpractice/Liability Insurance

Attach a copy of malpractice insurance face sheet

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 FORM

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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

Double check that the application is complete!