Behavioral Health – Institutional Provider Credentialing Application ONLINE

(For UB Claim Submission)

Only psychiatric PHP and IOP facilities are required to attest to the appropriate corresponding program criteria attached.
If you have any questions, please call 800-756-2749 or send an email to prov.net@bcbsnd.com.

Institutional Provider Type *(Place a check next to ALL correct classifications)*

Psychiatric

- ☐ Residential Treatment Center (RTC)
- ☐ Partial Hospitalization Program (PHP)
- ☐ Intensive Outpatient Program (IOP)

Substance Use

- ☐ Residential Treatment Center (RTC)
- ☐ Partial Hospitalization Program (PHP)
- ☐ Intensive Outpatient Program (IOP)

Hospital

- ☐ Psychiatric Hospital

Institutional Provider 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 Phone #	Billing Fax #
Credentialing Contact Name and Phone #		Credentialing Contact Email	
Name and Title of Chief Administrator		Total Licensed Bed Capacity	
Facility accepts *(Check all that apply):* ☐ Credit Card ☐ Debit Card ☐ Neither			

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			
Joint Commission Accreditation or other CMS approved accreditation with deeming authority			
Other			

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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*)

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Psychiatric – Partial Hospitalization Program (PHP) *(Please attest that your psychiatric program meets substance use licensing criteria below in lieu of ND state license)*

- Offers no less than twenty (20) hours of programming per week in a structured program.
- Offers the program no less than four (4) days per week. Length of stay to be determined by client condition and functioning.
- Advises clients of emergency services that are available twenty-four (24) hours per day, seven (7) days per week when program not in session.
- Offers combination of individual and group therapy as deemed appropriate by assessment and treatment plan.
- Offers medical and nursing services as deemed appropriate by assessment and treatment plan.
- Offers a system for referral for needs identified but not available in the program.
- Offers family treatment services as deemed appropriate by assessment and treatment plan
- Offers educational and informational programming adaptable to individual client needs.

I attest that the Institution/Facility below meets all of the above program criteria.

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

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Intensive Outpatient Program (IOP) *(Please attest that your psychiatric program meets substance use licensing criteria below in lieu of ND state license)*

- Offers no less than eight (8) hours and no more than nineteen (19) hours of programming per week in a structured environment.
- Offers the program with length of stay to be determined by a client's condition and functioning
- Advises clients of emergency services that are available twenty-four (24) hours per day, seven (7) days per week when the program is not in session.
- Provides a combination of individual and group therapy as deemed appropriate by an assessment and treatment plan.
- Provides medical and nursing services as deemed appropriate by an assessment and treatment plan.
- Provides a system for consultation or referral for identified treatment needs if such services are not available in the program and which includes close coordination of such services by the program and an effort by the program to arrange needed medical or psychiatric services by telephone within twenty-four (24) hours of when the need was identified and in-person services within a time frame appropriate to the severity and issue.
- Provides family treatment services as deemed appropriate by an assessment and treatment plan.
- Provides educational and informational programming adaptable to individual client needs and developmental status.

I attest that the Institution/Facility below meets all of the above program criteria.

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

Please double check that the application is complete.

SUBMIT FORM

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

- **Email:**
  - **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

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