BCBS NC Blue Medicare

Credentialing Instructions

Licensed Certified Social Worker (LCSW) | Certified Substance Abuse Counselor (CSAC) | Licensed Clinical Addiction Specialist (LCAS) | Licensed Marriage and Family Therapist (LMFT) | Licensed Psychological Associate (LPA) | Licensed Professional Counselor (LPC) | Licensed Professional Counselor Associate (LPCA) | Certified Nurse Specialists (CNS)

- **Provider Evaluation Form**

  Dated within the past two years; forms from relatives or Partners not allowed. Blue Cross and Blue Shield of North Carolina requires **three** provider evaluation forms from the following providers:

  1. One from a Physician or Ph.D.
  2. One from a peer
  3. One from a previous supervisor (no interim supervisors)

  For Licensed Psychological Associate (LPA)

  1. One from Physician or Ph.D.
  2. One from previous supervisor
  3. One from current supervisor

  For Certified Substance Abuse Counselors (CSAC)

  1. One from Physician or Ph.D.
  2. One from previous supervisor
  3. One from current supervisor
     Note: If current supervisor has served as lone supervisor for entirety of CSAC professional carrier, a letter from a Master's level CSAC can serve as substitute for previous supervisor letter

  For Licensed Clinical Addiction Specialist (LCAS)

  1. One from Physician or Ph.D.
  2. One from another CCAS or Master's level CSAC
  3. One from previous supervisor

- **Copy of Masters degree** or certified transcript documenting completion of Masters degree
- **If you have a single medical malpractice judgment case settled for $200,000.00 or more**; or if you have multiple malpractice cases settled for any amount two letters of recommendation from physician peers are required.

For Licensed Professional Counselor (LPC) & Licensed Psychological Associate (LPA)

- **Complete the Attestation of Supervised Clinical Experience** –see attached form (minimum of 3,000 hours)

Provider Evaluation Form

Name of Applicant: _____

Relationship to Applicant:

☐ Peer ☐ Referring Physician ☐ Residency Program Director (MD, DO, Ph.D.) ☐ Previous Supervisor

☐ Supervising Physician ☐ Chief of Department/Staff where applicant has admitting privileges

The above provider is applying to participate in a managed care network(s). Letters of reference (LOR)/Evaluation forms from partners within the same practice will only be accepted if you attest that there is no financial conflict of interest. We also cannot accept LOR's/evaluation forms from a relative.

☐ **I attest that I have no financial Conflict of Interest nor am I a relative of the applicant.**

Please provide us with information below concerning his/her professional qualifications. All information submitted will be held in strict confidence.

Please complete all questions and use "NA" where applicable:

1. How long have you known the applicant? _____
2. How would you rate the applicant's professional abilities?
   ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor
3. How would you rate the applicant's ability to work and communicate with physician and non-physician staff?
   ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor
4. How would you rate the applicant's rapport with patients?
   ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor
5. List any strengths and weaknesses:
   ☐ N/A **Strengths:** _____
   _____
   ☐ N/A **Weaknesses:** _____
   _____
6. To your knowledge, has the applicant had any of the following:
   Malpractice claim(s)? . . . . . ☐ Yes ☐ No
   Problems with medical licensure, certification, or licensing boards? . . . . . ☐ Yes ☐ No
   Revocation, denial, or change in hospital privileges? . . . . . ☐ Yes ☐ No
   History of/or current impairment due to drugs and/or alcohol? . . . . . ☐ Yes ☐ No
   If your answer is yes to any of the above questions, please provide details:
   _____
7. Please provide any additional information that would be helpful to us in evaluating this applicant.
   _____

Legal Signature with Credentials: _____ **Date:** _____

Printed Name: _____ **Telephone Number:** _____

Address:

_____

Group Name **Street** **City** **State** **Zip**

Licensed Professional Counselor
ATTESTATION OF SUPERVISED CLINICAL EXPERIENCE

I hereby certify and attest that I meet the Blue Cross and Blue Shield of North Carolina credentialing criteria for "Other Master's Prepared Therapists" in that I have completed 3,000 hours of post-master's degree clinical practice under the supervision of a state-licensed practitioner in my area of specialty. I understand that if this information is subsequently found to be false, any agreement I may have with Blue Cross and Blue Shield of North Carolina and its affiliates will be terminated.

I hereby grant permission and consent for Blue Cross and Blue Shield of North Carolina and/or its designee, to obtain and verify information pertaining to my supervised experience. I consent to the release by the person, organization, or other entity to Blue Cross and Blue Shield of North Carolina and/or its designee, of all information that may be reasonably relevant to an evaluation of my supervised experience. I agree to hold harmless any such person or organization or other entity from any cause of action based on the release of such information to Blue Cross and Blue Shield of North Carolina and/or its designee.

_____ _____
Provider Signature Date

_____
Provider Name (Please print)

Supervisor's Name: _____

Location (City, State): _____

Duration of Supervision: _____
(Beginning and End Dates)

Number of Hours at each Site*: _____

If more than one site please attach additional sheets

NC Uniform Application Questionnaire

Provider Name:_____

7.	**Have you involuntarily or voluntarily withdrawn or been suspended from any internship, residency or fellowship training program? Please explain:**

8.	**Please explain any incident(s) in which you have involuntarily or voluntarily withdrawn your application for appointment, clinical privileges or reappointment before a decision was made by a hospital or healthcare facility's governing board.**

C. PROFESSIONAL INFORMATION

Please circle yes or no for the following questions. Please complete the attached Supplemental Form for any questions to which you answer "yes." Also, please sign and date this application. If this application does not have the provider's signature, it cannot be accepted.

	YES	NO
1. Has your license to practice in any jurisdiction ever been limited, restricted, reduced, suspended, voluntarily surrendered, revoked, denied or not renewed; have you ever been reprimanded by a state licensing agency; or are any of these actions pending with respect to your license; are you under investigation by any licensing or regulatory agency? *(If yes, please complete Supplemental Question No. 1.)*	Y	N
2. Has your professional employment or membership in a professional organization ever been subject to disciplinary proceedings, denied, limited, restricted, reduced, suspended, revoked, not renewed, or voluntarily relinquished during or under threat of termination for any reason? *(If yes, please complete Supplemental Question No. 2.)*	Y	N
3. Has your Drug Enforcement Agency registration or other controlled substance authorization ever been limited, restricted, reduced, suspended, revoked, denied, not renewed, or have you voluntarily surrendered or limited your registration during or under the threat of an investigation or are any such actions pending? *(If yes, please complete Supplemental Question No. 3.)*	Y	N
4. Have you ever been sanctioned or suspended by Medicare or Medicaid? *(If yes, please complete Supplemental Question No. 4.)*	Y	N
5. To your knowledge, have you ever been reported to the National Practitioner Data Bank or the North/South Carolina Board of Medical Examiners? *(If yes, please complete Supplemental Question No. 5.)*	Y	N
6. Have you ever been convicted of a felony or misdemeanor, or are you under investigation with respect to such conduct? *(If yes, please complete Supplemental Question No. 6.)*	Y	N
7. Has a professional liability claim been assessed against you in the past five years, or are there any professional liability cases pending against you? *(If yes, please complete Supplemental Question No. 7.)*	Y	N
8. Has any liability insurance carrier canceled, refused coverage, or rated up because of unusual risk or have any procedures been excluded from your coverage? *(If yes, please complete Supplemental Question No. 8.)*	Y	N
9. Have you ever practiced without liability coverage? *(If yes, please complete Supplemental Question No. 9.)*	Y	N
10. Do you currently have any medical, chemical dependency or psychiatric conditions that might adversely affect your ability to practice medicine or surgery or to perform the essential functions of your position? *(If yes, please complete Supplemental Question No. 10.)*	Y	N
11. Have your Hospital and/or Clinic privileges ever been limited, restricted, reduced, suspended, revoked, denied, not renewed, or have you voluntarily surrendered or limited your privileges during or under the threat of an investigation or are any such actions pending? *(If yes, please complete Supplemental Question No. 11).*	Y	N

SUPPLEMENTAL FORM

Provider Name: _____ ***Provider ID#*** _____
(If applicable)

1. *License Limited, Reprimanded, etc.*

List State(s) where action took place _____ _____ _____

Date(s) license revoked, suspended, etc. From ____/___/____ To ___/____/____

Please explain:_____

_____

_____

_____

_____

_____

2. *Employment/Membership Suspended, Limited, etc.*

List State(s) where action took place _____ _____ _____

List Professional Organization _____ _____ _____

Please explain:_____

_____

_____

_____

_____

_____

3. *Drug Enforcement Agency (DEA) Explanation*

List State(s) where action took place _____ _____ _____

Please explain:_____

_____

_____

_____

_____

_____

SUPPLEMENTAL FORM

Provider Name:_____Provider ID#_____
(If applicable)

4. *Medicare/Medicaid Sanction Disciplinary Action(s)*

Disciplined Action(s):_____
List State(s):_____ _____ _____ Date(s) of Action From____/___/____ To ___/____/____
Please explain:_____
_____
_____
_____
_____
_____

5. *National Practitioner Data Bank Report(s)*

Please explain the NPDB report *(if you have a copy please attach)*: _____
_____
_____
_____
_____
_____

6. *Felony or Misdemeanor*

Did you serve a sentence? ☐ Y ☐ N If YES, circle how many years 1 2 3 4 5 6 other_____
Please explain charge and verdict_____
_____
_____
_____
_____
_____ List State(s) _____ _____ _____

SUPPLEMENTAL FORM

Provider Name:_____Provider ID#_____
(If applicable)

7. *Named in Professional Liability Judgment, Settlement, etc.*

Please explain, include dates & amounts:

_____

_____

_____

_____

_____

8. *Canceled, Refused Coverage, etc.*

Please list Insurance Carrier(s) _____ _____

Please explain:_____

_____

_____

_____

_____

_____

9. *Practiced Without Liability Coverage*

Please explain:_____

_____

_____

_____

_____

_____

SUPPLEMENTAL FORM

ProviderName:_____ProviderID#_____
(If applicable)

10. ***Medical, Chemical Dependency, or Psychiatric Conditions***

Please explain in detail:_____

_____

_____

_____

_____

_____

11. ***Hospital or Clinic Privileges Revoked, Restricted, etc.***

List Hospital(s) _____ _____ _____

Date privileges revoked, suspended, etc. From____/___/____ To___/____/____

Please explain:_____

_____

_____

_____

_____

_____

Attestation Statement

(IMPORTANT: Submit Original Only)

This application is to be signed by each individual provider submitting an application.

Fill in each space with the name of the Health Plan for which you are applying.

No Stamps or Copies Please

All information submitted by me in this application, as well as any attachments or supplemental information, is true, current, and complete to my best knowledge and belief as of the date of signature below. I fully understand that any significant misstatement in this application may constitute cause for denial of my application or termination of a resulting participation agreement.

By application for membership in BCBS NC, I signify my willingness to appear for interview in regard to my application. I authorize BCBS NC to consult with administrators and members of the medical staffs of hospitals or institutions with which I have been associated and with others, including past and present malpractice carriers, who may have information bearing on the questions in this application. Upon request, I will obtain and provide to BCBS NC materials pertaining to my qualifications and competence, including, materials relating to complaints filed, any disciplinary action, suspension, or action to curtail my medical- surgical privileges. I further consent to the inspection by representatives of BCBS NC of all documents that may be material to an evaluation of my professional qualifications and competence.

I understand and agree that I, as an applicant, have the burden of producing adequate information for proper evaluation of my professional competence, character, ethics, and other qualifications and for resolving any doubt about such qualifications. I release from liability all representatives of BCBS NC for their acts performed in good faith and without malice in connection with evaluating my application and my credentials and qualifications, and I release from any liability, all individuals and organizations that provide information to BCBS NC in good faith and without malice concerning this application and I hereby consent to the release and verification of information relating to any disciplinary action, suspension, or curtailment of medical-surgical privileges to BCBS NC

I understand that if my application is rejected for reasons relating to my professional conduct or competence, BCBS NC, may report the rejection to the appropriate state licensing board and/or National Practitioner Data Bank. In the event I am accepted for participation in BCBS NC, I hereby consent to BCBS NC for inspection of my patient records relating to BCBS NC enrollees as necessary for its peer and utilization review purposes as permitted by state or federal law and regulation I further agree to notify BCBS NC in a timely manner (not to exceed 30 days) of any changes to the information on the initial application.

_____

PRINT NAME OF PROVIDER

_____

SIGNATURE OF PROVIDER

_____

DATE

Please Sign and Complete this Application