MIDLEVEL PROVIDERS ONLY

INSTRUCTION PAGE

BCBS Blue Medicare

1. Initial and date this cover page
2. Sign the attached Attestation (do not date it)
3. Provide the remaining information applicable to your specialty:

**PHYSICIAN ASSISTANTS**
Physician Assistant Scope of Practice Letter attached) - Completed by a supervising physician at your CHS practice

**NURSE PRACTITIONERS and/or Certified Nurse Midwives (PCP & Specialists)**
Provider Evaluation Form (attached) - Completed by a supervising physician at your CHS practice

**Urgent Care Midlevel Providers**
Provider Evaluation Form (attached) - Completed by current supervising physician of CHS
See separate attachments required for Urgent Care (attached)

**Behavioral Health Midlevel Providers**
Provider Evaluation Form (attached) - Completed by current supervising physician of CHS
See separate attachments required for Behavioral Health

Provider: please initial and date here
Initial_______ Date Completed _____________________

Additional Information: If you have a single medical malpractice judgment case settle for $200,000.00 or more; or if you have multiple malpractice cases settled for any amount: a letter of recommendation from the Chief of Staff or the Chief of Dept where you currently have hospital privileges is required, or if you do not have admitting privileges, two letters of recommendation from physician peers may be submitted.

Further details are available via BCBS Website at:
http://www.bcbsnc.com/content/providers/application/instructions.htm (select provider type for specific explanation)
CAROLINAS HEALTHCARE SYSTEM

Physician Assistant Scope of Practice Letter

Physician Assistant’s Name: ________________________________

Address: ________________________________________________

Supervising Physician:

Job responsibilities and duties performed (i.e. histories, physicals, hospital rounds, assisting in surgery, etc.)

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

How are the physician assistant’s patients admitted?

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

How is the physician assistant supervised by other physicians when you are unavailable?

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Supervising Physician’s Signature: ____________________________

Date: __________________________

*If additional space is needed, please attach pages.
CAROLINAS HEALTHCARE SYSTEM
Mid-level Evaluation Form

Name of Applicant: ____________________________________________________________

Relationship to Applicant:

☐ Peer ☐ Referring Physician ☐ MD, DO, or PhD ☐ Previous Supervisor ☐ Supervising Physician

The above provider is applying to participate with Carolinas Physician Network, Inc. Letters of reference (LOR)/Evaluation forms from partners within the same practice will 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 know the applicant? ________________________________________

   How long would you rate the applicant’s professional abilities?
   Excellen t  V erase Good    G ood     Fair     Poor

   How would you rate the applicant’s ability to work and communicate with physician and non-physician staff?

   How would you rate the applicant’s rapport with patients?

2. List any strengths and weaknesses:

   ☐ N/A  Strengths: ____________________________________________________________

   ☐ N/A  Weaknesses: _________________________________________________________

3. To your knowledge, has the applicant had any of the following: Yes  No

   Malpractice Claim(s)?

   Problems with medical licensure, certification, or licensing board?

   Revocation, denial, or change in hospital privileges?

   History of/or current impairment due to drugs and/or alcohol?

   If your answer is yes to any of the above questions, please provide details: ____________________________________________

4. Please provide any additional information that would be helpful to us in evaluating this applicant.__________________________________________________________

   ________________________________  ________________________________
   Legal Signature with Title: Printed Name: Telephone Number: ______________________

   ________________________________
   Address:

   ________________________________  ________________________________  ________________________________
   Group Name  Street  City  State  Zip
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)
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
## Provider Requirements for Urgent Care Setting

All Specialties must meet standard BCBSNC Credentialing criteria in addition to the following specialty specific criteria:

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Requirements</th>
</tr>
</thead>
</table>
| Family Practice Medicine/Pediatrics | • One (1) year of experience covering the full spectrum of care found in an Urgent Care setting (Attestation)  
• Board Certified by American Board of Family Practice or Completed Residency in Specialty  
• ACLS Certified  
• PALS/PLS Certified |
| Internal Medicine Pediatrics | • One (1) year of experience covering the full spectrum of care found in an Urgent Care setting (Attestation)  
• A letter(s) of recommendation that in whole speak to the applicant’s ability to provide the full spectrum of care (ie. Peds, GYN, Adult, Trauma) in an Urgent Care setting.  
• 2 years of CME related to the full spectrum of care found in an Urgent Care setting  
• ACLS Certified  
• PALS/PLS Certified |
| General Practice | • Two (2) years of experience covering the full spectrum of care found in an Urgent Care setting (Attestation)  
• A letter(s) of recommendation that in whole speak to the applicant’s ability to provide the full spectrum of care (ie. Peds, GYN, Adult, Trauma) in an Urgent Care setting.  
• 2 years of CME related to the full spectrum of care found in an Urgent Care setting  
• ACLS Certified  
• PALS/PLS Certified |
| All Other Specialties including Physician Assistant and Nurse Practitioners | • One (1) year of experience covering the full spectrum of care found in an Urgent Care setting (Attestation)  
• A letter(s) of recommendation that in whole speak to the applicant’s ability to provide the full spectrum of care (ie. Peds, GYN, Adult, Trauma) in an Urgent Care setting.  
Physician Assistants and Nurse Practitioners must submit 1 letter from a practitioner who supervised the PA or NP in the urgent/emergent setting.)  
• Physician Assistants must be Certified (PA-C)  
• 100 hours of CME within the past three (3) years addressing the variety of topics as outlined in the “Provider Attestation of Urgent Care Competencies” document  
• ACLS Certified  
• PALS/PLS Certified |
| Emergency Medicine | - One (1) year of experience covering the full spectrum of care found in an Urgent Care setting (Attestation)  
- Board Certified by American Board of Emergency Medicine or Completed Residency in Specialty  
- ACLS Certified**  
- PALS Certified**  

**For MD’s board certified in Emergency Medicine** - In lieu of ACLS and PALS/APLS, the most current LLSA and/or ConCert completion certificate is required; one of either must have been completed within the most recent 12-month period.

**For DO’s board certified in Emergency Medicine** – In lieu of ACLS and PALS/APLS for physicians currently board certified by the American Osteopathic Board of Emergency Medicine, the most current COLA completion certificate which must have been completed within the most recent 12-month period is required.
Provider Attestation of Urgent Care Competencies

I attest that the Midlevel Practitioner applicant, ______________________ has the skills, knowledge and experience to recognize, manage and triage urgent/emergent conditions in adults and pediatric patients including, but not limited to the following:

<table>
<thead>
<tr>
<th>Condition</th>
<th>Condition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chest Pain</td>
<td>Bradycardia</td>
</tr>
<tr>
<td>Shortness of Breath</td>
<td>Asthma/Wheezing</td>
</tr>
<tr>
<td>COPD</td>
<td>Pulmonary Embolism</td>
</tr>
<tr>
<td>Stridor</td>
<td>Croup</td>
</tr>
<tr>
<td>Epiglottitis</td>
<td>Airway Obstruction</td>
</tr>
<tr>
<td>Foreign Body Aspiration</td>
<td>Cyanotic Heart Disease</td>
</tr>
<tr>
<td>Sickle Cell Disease</td>
<td>Shock</td>
</tr>
<tr>
<td>Diabetic Ketoacidosis</td>
<td>Sepsis</td>
</tr>
<tr>
<td>Abdominal Pain</td>
<td>Appendicitis</td>
</tr>
<tr>
<td>Drug/ETOH Overdose</td>
<td>Anaphylaxis</td>
</tr>
<tr>
<td>Head Trauma</td>
<td>Headache (meningitis or bleed)</td>
</tr>
<tr>
<td>Fractures</td>
<td>Headache</td>
</tr>
<tr>
<td>Mental Status Changes</td>
<td>Stroke or TIA</td>
</tr>
<tr>
<td>Seizures (febrile and other)</td>
<td>Significant Lacerations</td>
</tr>
<tr>
<td>Mental Health Emergencies</td>
<td>Infectious Diseases (e.g., tick-borne diseases, meningitis, sepsis, etc.)</td>
</tr>
<tr>
<td>Burns</td>
<td></td>
</tr>
<tr>
<td>OB/GYN:</td>
<td></td>
</tr>
<tr>
<td>STD/PID</td>
<td>Postpartum Hemorrhage/Infection</td>
</tr>
<tr>
<td>Ectopic Pregnancy</td>
<td>Embolic Phenomena</td>
</tr>
<tr>
<td>Diagnosis of Pregnancy</td>
<td>Dysfunctional Uterine Bleeding</td>
</tr>
<tr>
<td>Bleeding in Pregnancy</td>
<td>Torsion of Ovarian Cyst</td>
</tr>
<tr>
<td>Preeclampsia/eclampsia/PIH</td>
<td>Evaluation Protocol of Rape/Domestic Abuse</td>
</tr>
<tr>
<td>Preterm Labor</td>
<td></td>
</tr>
<tr>
<td>Intrapartum Fetal Distress</td>
<td></td>
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</tbody>
</table>

I have read this list and confirm that the Midlevel Practitioner named above has the skills, knowledge and experience to recognize, manage and triage urgent/emergent conditions in adult and pediatric patients including, but not limited to the list presented above and I have reviewed the list presented above with the applicant Midlevel Practitioner and he/she is aware of and confirms that he/she has the required Urgent Care competencies listed above.

Primary Supervisor of Midlevel Practitioner (Physician’s Assistant and/or Family Nurse Practitioner)

Signature ___________________________________________ Date ____________

The practitioner will be notified in writing of the Credentialing Committee’s denial of their application for participation in the BCBSNC Managed Care Networks. Practitioners who are denied initial credentialing have no appeal process and must wait at least one year before reapplying. There may be exceptions if deemed appropriate by Credentialing Committee Chairman or Credentialing Committee.

Network Management notifies all practitioners of their effective date for participation with BCBSNC managed care network(s).