



# Ancillary Credentialing Application

To apply for ancillary network participation, complete this form and submit with the required supporting documentation for your provider type. Failure to submit all required information will result in application denial.

## Instructions

- 1. All fields are required. Complete this form in its entirety, including signature and date.
- 2. Gather all necessary required supporting documentation for your provider type as listed on the **Ancillary Credentialing Checklist**.
- 3. Submit your completed form and supporting documentation as noted below.

For these provider types:	Email the application and supporting documentation to:
<ul style="list-style-type: none"><li>• Durable medical equipment</li><li>• Home infusion therapy</li><li>• Orthotics and prosthetics</li></ul>	Standard Ancillary Contracting
<ul style="list-style-type: none"><li>• Behavioral health</li><li>• Birthing centers</li><li>• Coordinated home care</li><li>• Freestanding ambulatory surgery centers</li><li>• Freestanding dialysis</li><li>• Hospice</li><li>• Skilled nursing facility</li><li>• Specialized mental health rehab facility – Medicaid only</li><li>• Supportive living facility – Medicaid only</li></ul>	Ancillary Facility Contracting

We'll assign a case number once we receive all required information. If approved, we'll email you a contract for participation in the ancillary networks for which you qualify.

## Type of Request

Select one:	<input type="checkbox"/> Freestanding	<input type="checkbox"/> Hospital based	<input type="checkbox"/> Part of a hospital system
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Select one:	<input type="checkbox"/> Ambulatory surgery center (Submit roster of ASC physicians and surgeons on staff and joint venture relationship, if applicable)	<input type="checkbox"/> Durable medical equipment	<input type="checkbox"/> Skilled nursing facility
	<input type="checkbox"/> Behavioral Health	<input type="checkbox"/> Home infusion	<input type="checkbox"/> Skilled nursing facility (Type 63)
	<input type="checkbox"/> Coordinated home care	<input type="checkbox"/> Hospice	<input type="checkbox"/> Specialized mental health rehab facility
	<input type="checkbox"/> Dialysis	<input type="checkbox"/> Orthotics and prosthetics	<input type="checkbox"/> Supportive living facility

## Provider Information and Questionnaire

1. Provider name \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_ County \_\_\_\_\_  
Phone \_\_\_\_\_ Fax \_\_\_\_\_ Email \_\_\_\_\_  
Contracting entity (if applicable) \_\_\_\_\_
2. Payee name \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_  
Multiple locations? ☐ Yes ☐ No (If yes, complete a separate application and submit credentials for each location.)
3. Chief Executive Officer \_\_\_\_\_
4. Chief Financial Officer \_\_\_\_\_
5. Administrator/Director \_\_\_\_\_
6. Medical Director \_\_\_\_\_
7. Medical Director's  
National Provider Identifier \_\_\_\_\_
8. Medical Director's license number \_\_\_\_\_
9. Medical Director's board certification \_\_\_\_\_
10. Is the provider certified by Medicare? ☐ Yes ☐ No
11. Medicare provider number \_\_\_\_\_ Date of certification \_\_\_\_\_
12. Medicaid provider number \_\_\_\_\_ NPI \_\_\_\_\_
13. Federal tax identification number \_\_\_\_\_
14. State license number \_\_\_\_\_ Expiration date \_\_\_\_\_
15. Primary taxonomy? ☐ Yes ☐ No Selected taxonomy number \_\_\_\_\_ State \_\_\_\_\_
16. Is the provider accredited by an accrediting body? ☐ Yes ☐ No  
If yes, expiration date of accreditation \_\_\_\_\_ Accreditation provided by \_\_\_\_\_
17. Certificate of Insurance issued by \_\_\_\_\_ Effective date \_\_\_\_\_ Expiration date \_\_\_\_\_
18. How is the provider organized? (Select one)  
☐ Not-for-profit corporation ☐ For-profit corporation ☐ Partnership ☐ Sole proprietorship  
☐ Other (Explain) \_\_\_\_\_
  - a. If a corporation, attach a copy of the Articles of Incorporation and By-Laws. Label as 18a. ☐ Attached ☐ Does not apply
  - b. If the organization is an unlisted corporation for profit, attach a sheet listing names, addresses and business affiliations of all stockholders and amounts of stock held by each. Label as 18b. ☐ Attached ☐ Does not apply
  - c. If the organization is not a corporation, give the names, addresses and business affiliations of the owner or owners. Label as 18c. ☐ Attached ☐ Does not apply
  - d. If other than a sole proprietorship, attach a copy of the ownership agreement. Label as 18d. ☐ Attached ☐ Does not apply
19. Are there health-related organizations or professionals associated with the organization through ownership or control?  
☐ Yes ☐ No
20. Was provider previously contracted with BCBSIL under another name or ownership? ☐ Yes ☐ No (If yes, please provide the previous owner's name, Tax ID and NPI: \_\_\_\_\_)
21. Does the provider have any functions, activities or services being used offshore? ☐ Yes ☐ No  
If yes, what activities? \_\_\_\_\_
22. Select populations you have experience treating: (Select all that apply)  
☐ Homeless ☐ HIV/AIDS ☐ Physical disabilities ☐ Chronic illness  
☐ Serious mental illness ☐ Deafness or hard-of-hearing ☐ Blindness or visual impairment
23. Are the following standards in accordance with the Americans with Disabilities Act?  
Site accessible ☐ Yes ☐ No Parking accessibility ☐ Yes ☐ No Exterior building ☐ Yes ☐ No  
Interior building ☐ Yes ☐ No Exam table ☐ Yes ☐ No Exam room ☐ Yes ☐ No  
Office reception area ☐ Yes ☐ No Restroom ☐ Yes ☐ No Scale ☐ Yes ☐ No  
Close proximity to public transportation ☐ Yes ☐ No
24. Hours of operation: Sun \_\_\_\_\_ Mon \_\_\_\_\_ Tues \_\_\_\_\_ Wed \_\_\_\_\_ Thu \_\_\_\_\_ Fri \_\_\_\_\_ Sat \_\_\_\_\_
25. Languages spoken \_\_\_\_\_
26. Language line interpreter? ☐ Yes ☐ No

## Signature and Attestation

*I confirm that all the above information is true.*

### Application prepared by:

Name \_\_\_\_\_

Signature \_\_\_\_\_

Title \_\_\_\_\_

Date \_\_\_\_\_

Email \_\_\_\_\_

### Credentialing contact:

Name \_\_\_\_\_

Email \_\_\_\_\_