blue shield of california

blue shield of california Promise Health Plan

Blue Shield of California and Blue Shield of California Promise Health Plan Behavioral Health Network Application for Individual Practitioners

This application applies to Blue Shield of California and Blue Shield of California Promise Health Plan (collectively, "Blue Shield"). Please email completed documents to Blue Shield at bsc_specialtynetmmgt@blueshieldca.com

Blue Shield **requires** all providers to be enrolled with The Council for Affordable Quality Healthcare (CAQH)

Individual practitioner identifying information (complete an application for each practitioner)

Practitioner last name:	First name:	Middle Initial:
Date of birth:	Social security number (SSN):	
License type:		
Date accredited by CAQH:	CAQH ID number:	
National provider identifiers (NPIs)	Type 1:	Type 2:
Practitioner Ethnicity:		
Languages spoken:		

Nurse practitioners and physician assistants must complete a separate application. Supervising physicians must also be credentialed with Blue Shield.

Supervising physician name:	Phone number:
Supervising physician NPI:	

Individual practitioner practice location information

Attach a list with additional practice locations. Include practice hours and availability and Americans with Disabilities Act (ADA) accessibility for each additional location provided.

Practice name:		County:	
Address:	City:	State:	ZIP code:
Phone number:	Fax number:	Email:	
Vendor information (must match W9)			
Name:			
Tax identification number (TIN):		County:	
Address:	City:	State:	ZIP code:
Phone number:	Fax number:	Email:	
Accepting new patients: ☐ Yes ☐ No	After hours phone number:		

Practice hours and availability

Day	Start time	a.m./p.m.	End time	a.m./p.m.	Check if office closed on this day
Monday					☐
Tuesday					☐
Wednesday					☐
Thursday					☐
Friday					☐
Saturday					☐
Sunday					☐

Provider group/business practice location information

Attach a list with additional practice locations. Include practice hours and availability and ADA accessibility for each additional location provided.

Group name:		County:	
Address:	City:	State:	ZIP code:
Phone number:	Fax number:	Email:	
Group vendor information (must match W9)			
Name:			
Tax identification number (TIN):		County:	
Address:	City:	State:	ZIP code:
Phone number:	Fax number:	Email:	
Accepting new patients: ☐ Yes ☐ No	After hours phone number:		

Practice hours and availability:

Day	Start time	a.m./p.m.	End time	a.m./p.m.	Check if office closed on this day
Monday					☐
Tuesday					☐
Wednesday					☐
Thursday					☐
Friday					☐
Saturday					☐
Sunday					☐

Behavioral health contract

Services provided (check all that apply)		
☐ Autism spectrum disorder (ASD)	☐ Telehealth	☐ In person
Lines of business (check all that apply)		
☐ Commercial	☐ Medi-Cal	☐ Medicare
ADA Accessibility		
Does this office location meet ADA accessibility requirements? ☐ Yes ☐ No		
If yes, check areas below that meet ADA accessibility requirements:		
☐ Exam room	☐ Parking	☐ Exterior building
☐ Restroom	☐ Exam table/scale	☐ Interior building

Medi-Cal

Effective January 01, 2018, the Department of Managed Health Care Services (DHCS) has issued provider screening and enrollment requirements for Medi-Cal managed care plans (MCPs). To comply with DHCS All Plan Letter (APL) 17-019, Blue Shield is directing providers to complete the DHCS screening and enrollment process as a requirement to participate. To participate in the Blue Shield Medi-Cal Network you must either be enrolled in Medi-Cal **or** have submitted a Medi-Cal enrollment application to DHCS.

Are you enrolled in Medi-Cal? ☐ Yes ☐ No

If you are not enrolled in Medi-Cal, have you applied to DHCS? ☐ Yes ☐ No

If yes, include proof of status that DHCS has received your Medi-Cal enrollment application. If not, contact DHCS to apply for Medi-Cal enrollment.

Medicare

This section is for eligible license types as outlined by Centers for Medicare & Medicaid Services (CMS). If enrolled in Medicare, provide your Provider Transaction Access Number (PTAN): ☐

Practitioner specialties

Blue Shield requires practitioners to meet specific criteria for the specialty areas below. By checking the specialty box(es), you indicate that the practitioner meets the outlined requirements and requests to receive referrals for that specialty.

Please ensure the practitioner signs the Specialties Attestation following this section.

	Specialty	Requirements
☐	Adolescents Ages 13-17	Demonstration of adequate and relevant academic coursework or clinical training in adolescent treatment. For non-MD's at least 1500 hours supervised experience treating adolescents and families. In general, at least 30% of current practice involves the treatment of adolescents and their families.
☐	Substance Use Disorder	Demonstration of adequate and relevant academic coursework or clinical training in addictions/chemical dependency. For non-MD's, at least 1500 hours supervised experience treating clients with chemical dependence/addictions **OR** certification from the APA College of Professional Psychology (certification is for psychologists only). In general, at least 30% of current practice involves the treatment of addictions/chemical dependency.
☐	Autism Spectrum Disorder (ASD)	Demonstration of adequate and relevant continuing education units (CEU's), personal study, coursework and/or clinical training in the treatment of children. Demonstration of adequate and relevant CEU's, personal study, coursework and/or clinical training in the treatment of children with ASD and their families. At least five years' experience treating children with ASD and their families. At most times, at least 5% of current practice involves the treatment of children with ASD and their families.
☐	Children (ages 1-12)	Demonstration of adequate and relevant academic coursework or clinical training in the treatment of children. For non-MD's, at least 1500 hours supervised experience treating children and their families. In general, at least 30% of current practice involves the treatment of children and their families.
☐	Critical Incident/Stress Debriefing Response	Documentation of training and CEU's in Critical Incident Stress Debriefings (CISD). Evidence of a certificate of CISD training from the American Red Cross or the International Critical Incident Stress Foundation (ICISF) former Mitchell Model.
☐	Eating Disorders	Demonstration of adequate and relevant academic coursework or clinical training in eating disorders. For non-MD's, at least 1500 hours supervised experience treating clients with eating disorders. In general, at least 30% of current practice involves eating disorders.
☐	Eye Movement Desensitization and Reprocessing (EMDR)	Completion of an EMDR International Association (EMDRIA) approved program. At least 1500 hours of practical experience in EMDR
☐	Geriatric Therapy	Demonstration of adequate and relevant academic coursework or clinical training in geriatric treatment. For non-MD's, at least 1500 hours supervised experience in treating geriatric clients. In general, at least 30% of current practice involves the treatment of geriatrics.
☐	Neuropsychological Testing	Member of the American Board of Clinical Neuropsychology or the American Board of Professional Neuropsychology. Completion of Doctorate level courses in Neuropsychology within a regionally accredited institution. Completion of an internship, fellowship, or practicum in Neuropsychological Assessment at an accredited institution. At least 1500 hours of practical experience in Neuropsychological testing.
☐	Psychological Testing	Licensure as a Psychologist. Completion of Doctorate level courses in test construction, statistics, and measurement theories within a regionally accredited institution. At least 1500 hours of supervised experience administering, scoring, and interpreting psychological tests.
☐	Psychiatrist, Child	Proof of Board Certification in Child Psychiatry **OR** completion of a two-year fellowship in Child Psychiatry approved by the American Council on Graduate Medical Education.

Practitioner self-designated specialties (check all that apply)

☐	Attention Deficit/hyperactivity Disorder (ADHD)	☐	Adults	☐	Anger management
☐	Bipolar	☐	Child abuse	☐	Christian counseling
☐	Chronic/terminal illness	☐	Compulsive gambling	☐	Couples/marital depression
☐	Dialectical Behavior Therapy (DBT)	☐	Dyadic developmental psychotherapy	☐	Electroconvulsive therapy (ECT)
☐	Factitious disorders	☐	Family therapy	☐	First responders
☐	LGBTQIA+	☐	Gender dysphoria	☐	Grief/bereavement
☐	HIV	☐	Impulse control & conduct disorders	☐	Infertility
☐	Learning disabilities	☐	Military lifestyle issues	☐	Obsessive compulsive disorder (OCD)
☐	Organic disorders	☐	Pain management	☐	Panic/phobia
☐	Personality disorders	☐	Psychotic/schizophrenia	☐	Sex offender treatment
☐	Sexual dysfunction	☐	Sexual/physical abuse	☐	Sleep disorders
☐	Sign language capability	☐	Somatic symptoms and related disorders	☐	SPRAVATO®
☐	Trauma	Other:			

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Opioid treatment

Eligible practitioners must hold an MD, DO, PA, or advanced registered nurse practitioner (ARNP) license.

Do you possess a DATA 2000 Waiver from the Substance Abuse and Mental Health Services Administration (SAMHSA) allowing prescriptions for opioid addiction? ☐ Yes ☐ No If yes, provide DEA X-Waiver number:
Check all that apply: ☐ Buprenorphine/Suboxone ☐ Naltrexone Other:
Do you hold a specific Drug Enforcement Administration (DEA) number for Buprenorphine prescriptions for opioid addiction therapy? ☐ Yes ☐ No
DEA registration number: Expiration date:

Specialties attestation

I hereby attest that I meet the above requirements for all selected specialties.

Applicant signature:	Date:

Telehealth services

Do you provide telehealth services? ☐ Yes ☐ No

Provider is required to comply with all applicable state and federal laws related to the delivery of telemedicine and the Best Practices Guidelines published by the American Psychiatric Association and American Telemedicine Association.

Telehealth attestation

I hereby attest that I meet the above requirements for telehealth services.

Applicant signature:	Date:

Confidential questionnaire

Do you or a member of your family own, have an investment in, or otherwise have a business interest in any clinical laboratory, diagnostic testing center, hospital, surgery center, or other business dealing with the provisions of ancillary health services, equipment of supplies, other than the facility in which you practice? ☐ Yes ☐ No

If yes, please provide an explanation below. Failure to supply such information will result in delay or discontinuation of the credentialing process.

Required documentation

Document	Description
Licensure	Include a copy of the license certification or other supporting document(s) for the type of service(s) and provider/group business name with issue date and issuing agency/governing body.
Copy of approved filing from the California Secretary of State showing legal entity name	Include if you submit claims using a legal entity name
Signed W-9 or Department of Treasury/Internal Revenue Services (IRS) tax document	Include if you submit claims using an Employer Identification Number (EIN) or Tax Identification Number (TIN)
Copy of Articles of Incorporation	Include if incorporated and using an incorporated name
Fictitious Name Statement, issued by the county	Include if not incorporated and using a fictitious name
Documented proof of legal authorization to use a DBA	Include if using a DBA (conducting business under a name other than legal name). **Note:** if a DBA is to be registered with the State Licensing Board, include a copy of the Fictitious Name Permit.

All practitioners statement of understanding and release

I hereby certify that the information provided in this application is true and accurate and reflects my current level of training, experience, and demonstrated competence to practice with the clinical privileges that I have requested. I understand that I have the burden and legal responsibility of providing true and accurate information to demonstrate my professional competence, character, moral ethics, and other qualifications. I further understand that any significant misstatement or omission on this application may constitute cause for denial of participation or dismissal from Blue Shield or be subject to applicable state or federal penalties for perjury.

I agree to authorize Blue Shield, its representatives, or agents, to conduct criminal history records check and to consult with and inspect all documents from individuals and organizations having information bearing on my qualifications, including present and past professional liability insurance carriers, information concerning any restriction on my clinical privilege coverage, and any information concerning those cases which have been settled, lost, received judgment, or are pending. I further consent to the release of information concerning such proceedings or actions, and to the fullest extent permitted by law, release practitioners of such information from any and all liability.

I further authorize the copy of my signature on this document, as part of the application, to be as binding as the original. I agree that Blue Shield, its representatives, and individuals or entities providing information to Blue Shield in good faith shall not be liable for any act or occasion related to the evaluation or verification contained in this document, which is part of the application. I further agree to notify Blue Shield in a timely manner of any change to the information requested in this application. Information requested in this application not publicly available will be treated as confidential by Blue Shield.

I declare under penalty of perjury that my license(s) is/are in good standing. I agree to notify Blue Shield within ten (10) days of any change to the status of my license, or any investigation into my licensure, and I agree to forward a copy of my updated license and insurance upon renewal.

Applicant signature:	Date: