Excellus

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This enrollment application is only used for participation with Excellus Health Plan.

# ENROLLMENT APPLICATION
# REQUIRED DOCUMENT CHECKLIST

Please submit current copies of ALL of the documentation listed below.
Any missing or inaccurate information will delay the enrollment process.

| | |
|---|---|
| ☐ | Application for Practitioner Enrollment<br>• Complete all sections and especially the ***required*** fields, Social Security number and Taxonomy Code.<br>• All addresses: Primary Office Remittance, Correspondence, Medical Records. |
| ☐ | A council for Affordable Quality Health Care (CAQH) number may be required. You can self-register on the CAQH website (www.caqh.org). Please ensure that your CAQH information is completed and released to us with the most up-to-date information. |
| ☐ | W-9 Request for Taxpayer Identification Number and Certification |
| ☐ | Proof of Malpractice (liability) insurance<br>• Minimum amount of $1 million per occurrence and $3 million aggregate. **Ensure certificate has current effective date,** expiration date, and coverage amounts. *(exception Doula)* |
| ☐ | Behavioral Health (BH) Certification, *if applicable.* |
| ☐ | Attestation for LMHC, LMFT, and LCSW, *if applicable.* |
| ☐ | **Doula Only.** Include a copy of NYS Medicaid provider enrollment approval letter ***and*** NYS Medicaid Doula Attestation form, signed by you, confirming that you have completed training for all core competencies. |
| ☐ | Disclosure Questions for Non-Credentialed Practitioners ***ONLY*** |
| ☐ | (Current) Curriculum Vitae (CV) |

In accordance with applicable NYS Public Health and Insurance Laws, applications are reviewed for credentialing within 60 days of receiving a completed application. A completed application includes a complete and accurate CAQH application, re-attested to within the last 90 days and includes all supporting documentation as required by the Health Plan.

If you have already completed your application with CAQH, please ensure that you have authorized all applicable organizations to access your data. Using the CAQH Universal Credentialing DataSource does not grant participation or constitute applying for participation with the Health Plan. If applicable, contact the Health Plan directly to request contracting information.

You will receive notification of your participation status. Providers are not considered in-network/participating until applications are approved. If approved, you will be advised that you are an in-network provider and provided with an effective date of participation.

| **Region** | **Rochester** | **Central New York** | **Southern Tier** | **Utica** |
|---|---|---|---|---|
| **County** | Livingston, Monroe, Ontario, Seneca, Wayne, Yates | Cayuga, Cortland, Jefferson, Lewis, Onondaga, Oswego, St. Lawrence, Tompkins | Broome, Chemung, Chenango, Schuyler, Steuben, Tioga | Clinton, Delaware, Essex, Franklin, Fulton, Hamilton, Herkimer, Madison, Montgomery, Oneida, Otsego |
| **Email** | **Provider.enrollment@excellus.com** | | | |
| **Fax number** | 1-855-376-1068 | | | |
| **Address** | Excellus BCBS, Attn: Provider Relations, 333 Butternut Dr., Syracuse, NY 13214 | | | |

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# Application for Practitioner Enrollment

This application is only used for participation with Excellus Health Plan. Copies of your diploma, licenses, malpractice (Liability) insurance, and W-9 must be attached. Enrollment will not be processed without this documentation.

**All fields must be completed.**

By signing this application, I attest to not providing Telehealth only services and understand that I must maintain a physical practice location within the Health Plan's geographic service area to be considered for an in network participation.

| Applying as: | ☐ PCP | ☐ Specialist | ☐ Allied/Consulting Health Professional |
|---|---|---|---|

| Last Name: | First Name: | Middle Initial: |
|---|---|---|
| Date of Birth: | Social Security #: | Gender: ☐ Female ☐ Male |
| Individual NPI #: | CAQH Provider ID *(required)*: | |
| Language(s) spoken other than English: | Experienced HIV/AIDS Provider ☐ Yes ☐ No | |

| Race/Ethnicity - *for reporting purposes only.* | |
|---|---|
| American Indian or Alaskan Native (Not Hispanic or Latino) ☐ | Other ☐ |
| Asian (Not Hispanic or Latino) ☐ | Prefer Not to Say ☐ |
| Black or African American (Not Hispanic or Latino) ☐ | Two or More Races (Not Hispanic or Latino) ☐ |
| Hispanic or Latino ☐ | White/Caucasian (Not Hispanic or Latino) ☐ |
| Native Hawaiian or other Pacific Island (Not Hispanic or Latino) ☐ | |

| Individual Tax ID #: | |
|---|---|
| Group Name *(if applicable)*: | |
| Group Tax ID #: | Group NPI(s) #: |
| Primary Specialty: | Taxonomy Code: |
| Second Specialty: | Taxonomy Code: |
| License # & State: | DEA # & State: |
| Medicare #: | Medicaid #: To be enrolled in Medicaid products, an active Medicaid ID number is required. |

**Proceed to Page 3 for additional required information.**

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## Credentialed *(Select one provider type)*

For additional information regarding the credentialing process, please visit Join Our Network | Providers | Excellus BlueCross BlueShield (excellusbcbs.com)

In accordance with applicable NYS Public Health and Insurance Laws, applications are credentialed within 60 days of receiving a completed application. *Practitioners required to complete the Credentialing process will be provided an approval/effective date determined by the Health Plan.*

| | | |
|---|---|---|
| ☐ Acupuncturist (LAC) | ☐ Genetic Counselor (MS) | ☐ Occupational Therapist (OT) |
| ☐ Audiologist (AUD) *Will you dispense hearing aids?* ☐ Yes ☐ No If YES, list taxonomy code: _____ | | |
| ☐ Certified Diabetic Educator (CDE)[1] | ☐ Licensed Behavioral Analyst (ABA) | ☐ Optometrist (OD) |
| ☐ Certified Nurse Midwife (CNM) | ☐ Licensed Clinical Social Worker (LCSW) | ☐ Oral Maxillofacial Surgery (DMD) |
| ☐ Certified Nurse Midwife - Home Birth (CNM) | ☐ Licensed Marriage & Family Therapist (LMFT) | ☐ Osteopathic Doctor (DO) |
| ☐ Clinical Psychologist (PHD/PSYD) | ☐ Licensed Mental Health Counselor (LMHC)[2] | ☐ Physical Therapist (PT) |
| ☐ Doctor of Chiropractic (DC) | ☐ Medical Doctor (MD/MBBS/BMED, etc.) | ☐ Radiologist including Tele-Radiologist |
| ☐ Doctor of Podiatric Medicine (DPM) | ☐ Nurse Practitioner, Primary Care | ☐ Registered Dietitian (RD)[1] |
| ☐ Enterostornal Therapy | ☐ Nurse Practitioner, Psychiatry | ☐ Speech Pathologist (SP/SLP) |
| | | [1] INDEPENDENT<br>[2] NOT FACILITY BASED MUST COMPLETE PAGE 7 |

## Non Credentialed *(Select one provider type)*

*Requested Effective Date:* _____ | *Non-credentialed providers will receive a **30-day backdate** only.*

*If you selected one of the provider types **below**, you **must** complete the disclosure questions on page 7.*

| | | |
|---|---|---|
| ☐ Anesthesiologist *Do you provide Pain Management? ** ☐ Yes ☐ No If Yes, you must be credentialed. | | |
| ☐ Certified Diabetic Educator (affiliated with Physician Group or Hospital) | ☐ Hospitalist (a dedicated in-patient physician who works exclusively in a hospital) | |
| ☐ Certified Registered Nurse Anesthetist (CRNA) | ☐ Locum Tenens | ☐ Registered Dietician (RD) (affiliated with Physician Group or Hospital) |
| ☐ Emergency Medicine | ☐ Pathologist | ☐ Doula |

*Have you, your agent, or managing employee ever been convicted of a crime relating to Medicare, Medicaid or any government health program or the furnishing of, or billing for, medical care, services, or supplies or which is considered an offense involving theft or fraud or an offense against public administration or against public health and morals?*

☐ Yes ☐ No If Yes,please provide the following: Name/Title, DOB, Address, SSN:

| | |
|---|---|
| By checking this box you are opting-in to receiving e-alerts & correspondence via email Provider email address will need to be provided ☐ | Provider's Email Address *(please type or print):* |
| Office/Credentialing Contact name (Please print or type): | |
| Office/Credentialing Contact email address (Please print or type): | |
| Office/Credentialing Contact phone number (Please print or type): | |
| I hereby attest that the above information is true and accurate to the best of my knowledge. | |
| Practitioner's signature *(required)* _____ | Date: |

**Proceed to Page 4 for address information.**

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# Application for Practitioner Enrollment

All fields within each section must be completed, if being used.

**Please provide the *required* addresses: Primary Office, Correspondence, Remittance, *and* Medical Records. Each address can be the same or different, but must be identified as a valid United States Postal Service mailing address. If PO BOX information is used, the corresponding City, State and ZIP Code for the PO BOX must be provided and no street level information present. Office addresses must be identified by street level information with the corresponding City, State and Zip Code. PO BOX information is *not* allowed.**

**AN ADDRESS TYPE MUST BE CHECKED FOR EACH ADDRESS SECTION USED.**

## Address A

☐ Primary Address ☐ Additional Address ☐ Remittance ☐ Correspondence ☐ Medical Record

Address: Ste: City State: Zip Code:

Phone: Fax: Is this address Handicap accessible? ☐ Yes ☐ No

Is this address used for "Telehealth services." ☐ Yes ☐ No

Provider Hospitalist at this address ☐ Yes ☐ No

Are patients able to schedule an appointment at this location? ☐ Yes ☐ No

Hours available to see patients Mon ___-___ Tues ___-___ Wed ___-___ Thu ___-___ Fri ___-___ Sat ___-___ Sun ___-___

## Address B

☐ Primary Address ☐ Additional Address ☐ Remittance ☐ Correspondence ☐ Medical Record

Address: Ste: City State: Zip Code:

Phone: Fax: Is this address Handicap accessible? ☐ Yes ☐ No

Is this address used for "Telehealth services." ☐ Yes ☐ No

Provider Hospitalist at this address ☐ Yes ☐ No

Are patients able to schedule an appointment at this location? ☐ Yes ☐ No

Hours available to see patients Mon ___-___ Tues ___-___ Wed ___-___ Thu ___-___ Fri ___-___ Sat ___-___ Sun ___-___

## Address C

☐ Primary Address ☐ Additional Address ☐ Remittance ☐ Correspondence ☐ Medical Record

Address: Ste: City State: Zip Code:

Phone: Fax: Is this address Handicap accessible? ☐ Yes ☐ No

Is this address used for "Telehealth services." ☐ Yes ☐ No

Provider Hospitalist at this address ☐ Yes ☐ No

Are patients able to schedule an appointment at this location? ☐ Yes ☐ No

Hours available to see patients Mon ___-___ Tues ___-___ Wed ___-___ Thu ___-___ Fri ___-___ Sat ___-___ Sun ___-___

## Address D

☐ Primary Address ☐ Additional Address ☐ Remittance ☐ Correspondence ☐ Medical Record

Address: Ste: City State: Zip Code:

Phone: Fax: Is this address Handicap accessible? ☐ Yes ☐ No

Is this address used for "Telehealth services." ☐ Yes ☐ No

Provider Hospitalist at this address ☐ Yes ☐ No

Are patients able to schedule an appointment at this location? ☐ Yes ☐ No

Hours available to see patients Mon ___-___ Tues ___-___ Wed ___-___ Thu ___-___ Fri ___-___ Sat ___-___ Sun ___-___

*If there are additional locations that exceed this page, include an additional page with the required information for each location.*

◊ *Is this address Handicap Accessible?* ◊ *Are patients able to schedule an appointment at this location?*

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# Attestation for:

**Licensed Mental Health Counselor (LMHC)**
**Licensed Clinical Social Worker (LCSW)**
**Licensed Marriage & Family Therapist (LMFT)**

## Not for OMH or OASAS certified facility based counselors

In accordance with Excellus BlueCross BlueShield credentialing policies, including the credentialing/recredentialing criteria for Licensed Mental Health Counselors, and my participation agreement with Health Plan, I attest to the following:

| | |
|---|---|
| A. | I will practice within the scope of practice defined by the New York State Department of Education Office of Professions. |
| B. | I will clearly define in each client's notes:<br>1. The full name of the medical doctor who is credentialed to establish the mental health or chemical use diagnosis I am using to bill with*, and<br>2. The date this diagnosis was made, and<br>3. The full name of the medical doctor I consult with in the respective member's mental health and or substance use treatment.* |
| C. | I will make my records available upon request for quality, compliance, auditing, billing or other purposes in accordance with the terms of my participation agreement with Health Plan. |
| D. | I will ensure my medical record documentation, including initial assessments, treatment plans, progress notes, and psychotherapy, appropriately align with the member's plan of care, and are readily available upon request. |
| E. | ☐ I am a LMHC, LCSW, LMFT with 6 years of post-graduate degree clinical practice experience under the supervision of a qualified licensed mental health professional. |
| F. | ***LMHC only*** -<br>I am (select one or all that apply):<br>☐ A participating LMHC with Health Plan, practicing and being supervised by an employee of an OMH clinic.*<br>☐ A participating LMHC with Health Plan, practicing and being supervised in a practice in which the diagnosis and required supervision of cases is provided by an LCSW-R, PhD or Psychiatrist.*<br>☐ Employed by or co-located in a primary care office, in which the diagnosis is established by a Health Plan participating physician, physician's assistant or nurse practitioner.* |
| G. | I have read and fully understand my obligations under the Health Plan's Telemedic and Telehealth Policy 1.01.49. |
| H. | I have read and fully understand my obligations under the Health Plan's Credentialing/Recredentialing Criteria Non-Physician Health Care Practitioner, Licensed Mental Health Counselor Policy, Licensed Marriage & Family Therapist, Licensed Clinical Social Worker. |

Print Name: _____ Date: _____

Signature: _____

* In accordance with the New York State Department of Education, Office of Professions, if an LMHC is continuously treating a client for mental health or substance use DSM diagnosis, the LMHC must have a medical doctor complete a medical evaluation and consultation to determine and advise the LMHC whether the memeber is in need of medical care, and if so, for what illness, diagnosis or treatment.

| **Region:** | **Rochester** | **Central New York** | **Southern Tier** | **Utica** |
|---|---|---|---|---|
| **County:** | Livingston, Monroe, Ontario, Seneca, Wayne, Yates | Cayuga, Cortland, Jefferson, Lewis, Onondaga, Oswego, St. Lawrence, Tompkins | Broome, Chemung, Chenango, Schuyler, Steuben, Tioga | Clinton, Delaware, Essex, Franklin, Fulton, Hamilton, Herkimer, Madison, Montgomery, Oneida, Otsego |
| **Email** | **Provider.enrollment@excellus.com** | | | |
| **Fax Number:** | 1-855-376-1068 | | | |
| **Address:** | Excellus BCBS, Attn: Provider Relations, 333 Butternut Dr., Syracuse, NY 13214 | | | |

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# BEHAVIORAL HEALTH PROVIDERS (BH) Certification

## CONVERSION THERAPY

I _____ attest to the following;
[First Name, Middle Initial, Last Name]

| | |
|---|---|
| ☐ | I am a mental health professional participating/seeking to participate in the Excellus BlueCross BlueShield provider network. |
| ☐ | I will not provide conversion therapy to minors who are Excellus BlueCross BlueShield members and I will not seek reimbursement from Excellus BlueCross BlueShield for such services. |
| ☐ | I understand that "conversion therapy" is defined as "any practice by a mental health professional that seeks to change an individual's sexual orientation or gender identity, including efforts to change behaviors, gender expressions, or to eliminate or reduce sexual or romantic attractions or feeling toward individuals of the same sex." |
| ☐ | I will comply with all other applicable laws, rules, regulations and Excellus BlueCross BlueShield policies regarding conversion therapy. |

Print Name: _____ Date: _____

Signature: _____

| **Region:** | **Rochester** | **Central New York** | **Southern Tier** | **Utica** |
|---|---|---|---|---|
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| **Fax Number:** | 1-855-376-1068 | | | |
| **Address:** | Excellus BCBS, Attn: Provider Relations, 333 Butternut Dr., Syracuse, NY 13214 | | | |

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# Disclosure Questions for Non-Credentialed Practitioners *ONLY*

**All questions *must* be completed by the following practitioners:**
**Anesthesiologist, Emergency Room, Hospitalist, Locum Tenens, Pathologist, CRNA, Doula**
**[Certified Diabetic Educator and Registered Dietician affiliated with Physician Group or Hospital]**

| | | |
|---|---|---|
| 1. | ☐ Yes ☐ No ☐ N/A | Has your license, registration or certification to practice in your profession ever been voluntarily or involuntarily relinquished, denied, suspended, revoked, restricted, or have you ever been subject to a fine, reprimand, consent order, probation or any conditions or limitations by any state or professional licensing, registration or certification board? |
| 2. | ☐ Yes ☐ No ☐ N/A | Have your clinical privileges or medical staff membership at any hospital or health care institution (either voluntarily or involuntarily) ever been denied, suspended, revoked, restricted, denied renewal or subject to probationary or to other disciplinary conditions (for reasons other than non-completion of medical record when quality of care was not adversely affected) or have proceedings toward any of those ends been instituted or recommended by any hospital or health care institution, medical staff or committee or governing board? |
| 3. | ☐ Yes ☐ No ☐ N/A | Have you ever been terminated for cause or not renewed for cause from participation, or been subject to any disciplinary action by any managed care organizations or health plans (including HMOs, PPOs, or provider organizations such as independent practice associations or private health organizations)? |
| 4. | ☐ Yes ☐ No ☐ N/A | Have your federal Drug Enforcement Administration and/or state controlled dangerous substances (CDS) certifications(s) or authorization(s) ever been challenged, denied, suspended, revoked, restricted, denied renewal, or voluntarily relinquished? |
| 5. | ☐ Yes ☐ No ☐ N/A | Are you currently or have you ever been the subject of an investigation by any hospital, licensing authority, DEA or CDS-authorizing entities, education or training program, Medicare or Medicaid program, regulatory agency, or any other private, federal or state health program or been a defendant in any civil action that is reasonably related to your qualifications, competence, functions or duties as a medical professional for alleged fraud, an act of violence, child abuse or a sexual offense or sexual misconduct? |
| 6. | ☐ Yes ☐ No ☐ N/A | To your knowledge, has information pertaining to you ever been reported to the National Practitioner Databank or Healthcare Integrity and Protection Data Bank? |
| 7. | ☐ Yes ☐ No ☐ N/A | Has your professional liability coverage ever been cancelled, restricted, declined or not renewed by the carrier based on your individual liability history? |
| ***For any "Yes" response, please provide a detailed explanation on a separate sheet.*** | | |
| "I hereby attest that the above information is true and accurate to the best of my knowledge'" | | |

Signature: _____ Date: _____

| **Region:** | **Rochester** | **Central New York** | **Southern Tier** | **Utica** |
|---|---|---|---|---|
| **County:** | Livingston, Monroe, Ontario, Seneca, Wayne, Yates | Cayuga, Cortland, Jefferson, Lewis, Onondaga, Oswego, St. Lawrence, Tompkins | Broome, Chemung, Chenango, Schuyler, Steuben, Tioga | Clinton, Delaware, Essex, Franklin, Fulton, Hamilton, Herkimer, Madison, Montgomery, Oneida, Otsego |
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