



# Limited Technical Privileging Application

**Fax completed form to 617-246-3163**

## Technical Component

Use this application if you would like to bill for the technical component of:

- ✓ **X-rays**
  - ✓ **Ophthalmic A Scans – CPT 76511, 76516**
  - ✓ **Limited/Follow-up Obstetrical Ultrasounds – CPT 76815, 76816**
- If you want to bill for the technical component of fluoroscopy or ophthalmic B scans, please submit the *Technical Diagnostic Imaging Application*.
  - Your practice or organization must own, lease, or otherwise incur the full usage cost of diagnostic imaging equipment.

## Professional Component

Practitioners associated with your practice or organization who would like to bill Blue Cross\* for the interpretation of diagnostic imaging should submit the *Professional Privileging Application* if they are not already privileged by us. You must receive approval before billing for these services.

## Ready to submit? Be sure to include the attachments

**Fax your completed application to 617-246-3163 with the following documents as they relate to your organization/practice. All documents must be current.**

- A signed and dated IRS Form W-9 showing the name and Tax ID number to which payments should be directed. A blank form is attached.
- Professional practices are strongly encouraged to have a unique NPI for each location, as it may facilitate claims processing.
- If applying for X-ray, submit all documents shown on page 4 in the Service Site Information section.

## About our evaluation of this application

Blue Cross\* will evaluate this application according to its completeness and the organization's ability to meet pre-established privileging criteria and network need, as determined solely by Blue Cross.

We reserve the unqualified right to reject any and all applications, subject to the terms of this application and applicable law.

By accepting this application for evaluation, we agree that any patient-specific or identifying information, any non-publicly available information that you designate as confidential set forth in this application, and any non-publicly available information that is obtained in the application process will remain confidential unless its release is required or permitted by law, regulation, or valid court order.

We will send the privileging decision to the email on the last page of this application.

You may contact us about the status of your participation at [providerapplicationstatus@bcbsma.com](mailto:providerapplicationstatus@bcbsma.com) or 1-800-316-BLUE (2583).

\* Blue Cross refers to Blue Cross and Blue Shield of Massachusetts, Inc., Blue Cross and Blue Shield of Massachusetts HMO Blue®, Inc., and/or Massachusetts Benefit Administrators LLC, based on Product participation.

**Please check all that apply:**

- You want to bill for the technical component of a new modality
- You are already privileged for the technical component and are adding a service site
- You are changing service site information, such as diagnostic imaging equipment or personnel

Other (please explain)

**Organization information**

|  |  |
|--|--|
| Provider's legal name                        | <input style="width: 100%; height: 25px;" type="text"/>                          |
| DBA (as it appears on the W-9)               | <input style="width: 100%; height: 25px;" type="text"/>                          |
| Type of organization                         | <input type="checkbox"/> Facility <input type="checkbox"/> Professional practice |
| Tax ID number<br>(same number as on the W-9) | <input style="width: 100%; height: 25px;" type="text"/>                          |
| National Provider Identifier (NPI)           | <input style="width: 100%; height: 25px;" type="text"/>                          |
| Medicare participating provider number       | <input style="width: 100%; height: 25px;" type="text"/>                          |

**Main business location**

|                  |   |
|------------------|---|
| Address          | <input style="width: 100%; height: 25px;" type="text"/>   |
| City, state, zip | <input style="width: 100%; height: 25px;" type="text"/>   |
| Phone/Fax        | <input style="width: 60%; height: 25px;" type="text"/> <input style="width: 40%; height: 25px;" type="text"/> |

**Management or parent company**

|                                   |   |
|-----------------------------------|---|
| Management or parent company name | <input style="width: 100%; height: 25px;" type="text"/>   |
| Address                           | <input style="width: 100%; height: 25px;" type="text"/>   |
| City, state, zip                  | <input style="width: 100%; height: 25px;" type="text"/>   |
| Phone/Fax                         | <input style="width: 60%; height: 25px;" type="text"/> <input style="width: 40%; height: 25px;" type="text"/> |

## Service site information

**Copy and complete pages 3 and 4 for each location where you would like to bill for the technical component. All sites submitted with this application must bill using the same Tax ID number.**

By checking this box, I acknowledge that my organization must immediately submit a new application when there are changes to any of the service site information below.

### Service site

Site #  of  (total number of service sites)

Please enter your primary site as Site #1

|  |  |  |
|--|--|--|
| Site name                              |  |  |
| Address                                |  |  |
| City, state, zip                       |  |  |
| Phone to schedule appointments/Fax     |  |  |
| NPI for this site                      |  |  |
| Medicare participating # for this site |  |  |

### Billing address

Same as...  This site  Main business location  Management/parent company  Other:

|                      |  |  |
|----------------------|--|--|
| Billing company name |  |  |
| Address 1            |  |  |
| Address 2            |  |  |
| City, state, zip     |  |  |
| Phone/Fax            |  |  |

### Clinicians

Please list your on-site, supervising physicians.

| Name | NPI (Type 1) |
|------|--------------|
|      |              |
|      |              |
|      |              |

Please list each technologist on staff at this site.

| Name | License or registration # | Modality |
|------|---------------------------|----------|
|      |                           |          |
|      |                           |          |
|      |                           |          |
|      |                           |          |

Please list the Blue Cross participating physicians, chiropractors, optometrists, or podiatrists who provide professional interpretation.

Any who are not privileged by Blue Cross should submit the *Professional Privileging Application*.

| Name | NPI (Type 1) | Specialty |
|------|--------------|-----------|
|      |              |           |
|      |              |           |
|      |              |           |

### Imaging modalities

Enter the information **only** if your organization owns, leases, or otherwise incurs the full usage cost of the equipment at this site.

| Imaging modality at this site  | How many machines at this site | How many licensed technologists or practitioners perform the technical component at this site | Required documents for this site |
|--|--------------------------------|---|----------------------------------|
| X-ray  |                                |   | See list below                   |
| Ophthalmic A scans<br>CPT codes 76511 and 76516                          |                                | N/A   | None                             |
| Obstetrical ultrasounds (limited/follow-up)<br>CPT codes 76815 and 76816 |                                |   | None                             |

#### List of X-ray documents required for this site

Write these two numbers on every document:

- Site # from the top of page 4

- Item # shown below

| Item #                      |   |
|-----------------------------|---|
| <input type="checkbox"/> 1  | Annual inspection reports for the current year (physicist report, such as FX Masse-Diagnostic X-Ray survey). If recommendations are noted on the survey, please provide a statement outlining how issue was addressed/resolved.   |
|                             | Quality assurance/quality control plans specific to your facility, which should include descriptions of:  |
| <input type="checkbox"/> 2  | How you minimize radiation exposure to patients, staff, and the public  |
| <input type="checkbox"/> 3  | How you ensure the quality of diagnostic information  |
| <input type="checkbox"/> 4  | How you use, store, and dispose of hazardous materials and equipment  |
| <input type="checkbox"/> 5  | How you address medical and other emergencies   |
|                             | Your safety hazard monitoring plan, which should include descriptions and/or copies of:   |
| <input type="checkbox"/> 6  | Pregnancy questionnaire   |
| <input type="checkbox"/> 7  | Infection control process   |
| <input type="checkbox"/> 8  | Blood-borne pathogen exposure response  |
| <input type="checkbox"/> 9  | Medical emergency response  |
| <input type="checkbox"/> 10 | Radiation safety procedures and appropriate signage   |
| <input type="checkbox"/> 11 | Shielding records   |
| <input type="checkbox"/> 12 | Floor plan  |
| <input type="checkbox"/> 13 | A copy of the credentials for your Radiation Safety Officer (RSO). Enter the name of your RSO below.<br><br>The RSO is the on-site specialist who is responsible for overseeing the quality of radiation safety for the facility and personnel. For details about the credentials of an RSO, see Section 5 of the AAPM report:<br><a href="https://www.acr.org/-/media/ACR/Files/Radiology-Safety/Radiation-Safety/Radiation-Safety-Officer-Qualifications.pdf">https://www.acr.org/-/media/ACR/Files/Radiology-Safety/Radiation-Safety/Radiation-Safety-Officer-Qualifications.pdf</a> |
|                             | <b>Name</b> <input style="width: 200px; height: 20px;" type="text"/>  |
| <input type="checkbox"/> 14 | Equipment maintenance log for the past 12 months, if available; for a new office, please submit a sample form   |
| <input type="checkbox"/> 15 | Procedures and policies for operating imaging equipment   |
| <input type="checkbox"/> 16 | Documented process for retake rates that are measured and discussed quarterly   |
| <input type="checkbox"/> 17 | Medical record reporting and retention policies and standards   |
| <input type="checkbox"/> 18 | Record management and storage policies  |
| <input type="checkbox"/> 19 | Radiologic Technologist License for personnel operating the equipment (technologist or practitioner)  |
| <input type="checkbox"/> 20 | Current registration from the Mass. Department of Public Health's Radiation Control Program<br><br>If the name on the registration is different than your organization's legal name on page 2, please attach a letter of explanation.   |

## Representations

*By checking this box, I hereby affirm and represent that all statements, answers, and information included in this application are true and complete to the best of my knowledge and belief, and that I am duly authorized to provide information on behalf of the provider named on page 2.*



Name of person completing form

Title

Business name

Email

(required)

Date

|  |
|--|
|  |
|  |
|  |
|  |
|  |

**Fax your completed, signed application to 1-617-246-3163. Keep a copy for your files.**