Print Clear form

MASSACHUSETTS

A QUICK GUIDE TO THE RECREDENTIALING APPLICATION

Fax your completed application to **1-617-246-3163**.

We value your participation in our network(s). To maintain your active status in our credentialed network, you must complete the recredentialing process every two years. Please notify us in writing if you are no longer practicing and/or no longer wish to participate as a network provider.

Our provider agreements require providers to participate in our recredentialing process to participate in our provider networks. Failure to become recredentialed may lead to:

- Cessation of claims payment
- Termination from the BCBSMA credentialed provider networks
- Removal from BCBSMA provider directories
- Any other action by BCBSMA pursuant to your BCBSMA provider agreement

REQUIRED DOCUMENTS

Please include the following documents with this recredentialing application:

ORAL AND MAXILLOFACIAL SURGEONS

- Current Advanced Cardio Life Support Certificate (ACLS)
- Current federal DEA certificate
- Dentistry anesthesia permit
- Facility permit (hospital or dental school settings must submit a copy of their current Joint Commission certificate or Commission on Dental Accreditation from the American Dental Association certificate)
- Hospital affiliation verification letter
- A written description of your current arrangement for admitting BCBSMA members to a BCBSMA participating hospital
- Current Malpractice Insurance Face Sheet (or complete the insurance attestation form located at the end of this application)

DENTISTS

- Current federal DEA certificate (does not apply to dentists who practice orthodontics exclusively)
- Current Malpractice Insurance Face Sheet

SUBMIT YOUR COMPLETED PACKET ON TIME

Please return your completed recredentialing packet to us within 30 days of receiving it by mail. We will return any incomplete packets with a list of missing information. If any of the documents expire before you are recredentialed, we will contact you for updated document copies.

QUESTIONS?

IF YOU ARE A/AN	PLEASE CALL
Oral surgeon	Network Management and Credentialing Services at **1-800-316-2583**
Dentist:	Dental Provider Services at **1- 800-882-1178**

MASSACHUSETTS

RECREDENTIALING APPLICATION FOR DENTISTS AND ORAL SURGEONS

Fax your completed application to **1-617-246-3163**.

PROVIDER INFORMATION

Name:		NPI:	
Title:		License #:	
Date of birth:		SSN:	
Phone number:		DEA:	
Email address:		DEA expiration date:	

For oral and maxillofacial surgeons only		
Are you Board-certified? ❑ Yes ❑ No	Hospital affiliation:	
Was Hospital Privilege Verification Letter sent to hospital? ❑ Yes ❑ No		

PRACTICE INFORMATION

Please indicate all site addresses and telephone numbers at which you currently practice. Attach additional pages as needed.

Primary address:			
Phone #:		Fax #:	
Is/does this site:			
…ADA accessible? ❑ Yes ❑ No		…on public transit? ❑ Yes ❑ No	
…have interpreter services? ❑ Yes ❑ No		…have TDD device? ❑ Yes ❑ No	
Languages spoken:			
Evening office hours:		Weekend office hours:	
Other practice address:			
Phone #:		Fax #:	
Is/does this site:			
…ADA accessible? ❑ Yes ❑ No		…on public transit? ❑ Yes ❑ No	
…have interpreter services? ❑ Yes ❑ No		…have TDD device? ❑ Yes ❑ No	
Languages spoken:			
Evening office hours:		Weekend office hours:	

INSURANCE INFORMATION

Insurance carrier:				Policy #:	
Coverage dates:	From:		To:		
	(mm/dd/yyyy)			*(mm/dd/yyyy)*	
I have and maintain professional liability insurance in the amount of a minimum of $1 million per claim and $3 million aggregate.					
Signature:				Date:	

Provider name:	

PROFESSIONAL HISTORY/INFORMATION

For questions 1-18 only, please attach details for each yes answer. These questions refer to the past two years only, except as noted.

1.	Have any judgments been made against you in professional liability cases?	❑Yes	❑No
2.	Have settlements been made on your behalf in professional liability cases?	❑Yes	❑No
3.	Are there any professional liability claims or cases presently filed against you?	❑Yes	❑No
4.	Has your license to practice in any jurisdiction ever been denied, limited, suspended or revoked?	❑Yes	❑No
5.	Have you been denied medical staff membership or advancement in medical staff status, or has such denial been recommended by a standing staff or governing board?	❑Yes	❑No
6.	Have you voluntarily relinquished any medical staff membership?	❑Yes	❑No
7.	Has your membership, privilege or staff status at any hospital been limited, suspended, revoked, not renewed, or subject to probationary conditions, or has processing toward any of those ends been instituted or recommended by a staff committee or governing board?	❑Yes	❑No
8.	Has your request for any specific clinical privilege been denied or granted with stated limitations?	❑Yes	❑No
9.	Has your narcotic registration been denied, subjected to probationary conditions, suspended or revoked?	❑Yes	❑No
10.	Do you hold a narcotic registration in any other state?	❑Yes	❑No
11.	Have you been denied membership or renewal thereof, or been subjected to disciplinary action by any professional organization?	❑Yes	❑No
12.	Have you been the subject of any Blue Cross and Blue Shield, Medicare, Medicaid (any state) or any other medical reimbursement plan suspension or probation proceedings, or restricted from receiving payments from any Blue Cross and Rice Shield, Medicare, Medicaid (any state) or other third-party programs?	❑Yes	❑No
13.	Have you been the subject of any disciplinary actions by state or local medical societies, state board of examiners, or the DEA?	❑Yes	❑No
14.	Have you been convicted of a felony?	❑Yes	❑No
15.	Have you had an application for membership as a participating provider rejected by any HMO/PPO or other prepaid health care plan, or your contract as a participating provider terminated by any HMO/PPO or other prepaid plan?	❑Yes	❑No
16.	Are you **unable** to perform the procedures and the essential functions of the position for which you have applied or requested privileges, with or without reasonable accommodation, according to accepted standards of professional performance and without posing a direct threat to patients?	❑Yes	❑No
17.	Are you currently alcohol or chemical dependent or engaged in the illegal use of drugs?	❑Yes	❑No
18.	Have you been alcohol or chemical dependent or used illegal drugs within the last two years?	❑Yes	❑No
19.	Do you participate in Medicare and meet the conditions of participation in Medicare?	❑Yes	❑No
20.	Do you engage in sufficient clinical activity in your specialty to maintain clinical competency and provide for appropriate member access?	❑Yes	❑No
21.	Is the average time for patients to obtain a routine appointment less than three months?	❑Yes	❑No
22.	Is the average time for patients to obtain urgent appointments less than 24 hours?	❑Yes	❑No
23.	Do you have arrangements for 24-hour coverage (e.g., voicemail. beeper, etc.)?	❑Yes	❑No
24.	Do you prescribe medication in your practice?	❑Yes	❑No

Provider name:	

HOSPITAL AFFILIATION PROCESS

To be completed by oral and maxillofacial surgeons only

As part of the recredentialing process, we need to verify your hospital privileges. Please send the Hospital Privilege Verification letter and a photocopy of your Affirmation Statement and Release of Information Form to the medical staff office at your primary HMO Blue® hospital and your Medicare Advantage HMO hospital (if different from your HMO Blue hospital). Please return these to us within two weeks to complete your recredentialing application process.

IMPORTANT NOTE

You only need to send the Hospital Privilege Verification letter and copy of your Affirmation Statement and Release of Information Form to the medical staff office at your primary HMO Blue hospital if your primary or Medicare HMO Blue affiliation is with any of the following hospitals. Hospitals not listed below usually send us verification of your privileges. We will contact you if your hospital has not verified your privileges automatically.

Addison Gilbert Hospital
Berkshire Medical Center
Cambridge Hospital
Beth Israel-Deaconess Hospital-Needham
Fairview Hospital
Good Samaritan Medical Center
Holy Family Hospital
Lowell General Hospital
Lowell General-Saints Campus
Martha's Vineyard Hospital
Mt. Auburn Hospital
North Shore Medical Center-Union Hospital
Saint Anne's Hospital
Somerville Hospitals
Southern New Hampshire Medical Center
St. Elizabeth's Hospital
Whidden Hospital
Winchester Hospital

Provider name:	

HOSPITAL PRIVILEGE VERIFICATION LETTER

Oral and Maxillofacial surgeons: Please send to your primary hospital.

Hospital: Please fax this completed form to **1-617-246-3163** or mail to:

Blue Cross Blue Shield of Massachusetts
Provider Enrollment & Credentialing 03/02
25 Technology Place, 2nd Floor
Hingham, MA 02043

QUESTIONS?

Please call the Dental Provider Services at **1-800-882-1178**.

Date:		MD Name:	
Facility:		MD License #:	

In applying for credentialing/recredentialing to Blue Cross Blue Shield of Massachusetts, the physician named above has listed your facility as his/her primary practice site. Please provide the following information relative to this applicant:

1. Dates of association from initial date of appointment are: _____ to _____
2. Current medical staff status includes admitting privileges: ❑ Yes ❑ No
3. Unless otherwise noted, your facility has no known:
   a. pending or closed health care facility or public agency disciplinary action taken against this physician;
   b. alterations in privileges resulting, directly or indirectly, from concerns about this physician's professional performance, judgment, or clinical skills; and
   c. any other concerns related to this physician's professional performance, clinical skills, or mental or physical status, and any impairment related to chemical dependency.
4. If your facility is located within Massachusetts, is this physician currently credentialed by your facility pursuant to 243 CMR 3:05? ❑ Yes ❑ No
5. If your facility granted this physician **temporary privileges**, have they been granted pursuant to the JCAHO Medical Staff Services standards for temporary privileges? ❑ Yes ❑ No
6. If your facility is outside of Massachusetts, is this physician currently credentialed by your facility pursuant to JCAHO Medical Staff Services standards? ❑ Yes ❑ No

Thank you for your timely assistance with this important matter.

Signature:		Date:	
Title:			

Provider name:	

AFFIRMATION STATEMENT AND RELEASE OF INFORMATION FORM

I hereby affirm and represent that all statements, answers and information contained in and included with this application are true and complete to the best of my knowledge and belief. I understand that if there are changes to this document it is my responsibility to report them to Provider Enrollment. I understand and agree that acceptance of this application does not constitute approval or acceptance of participation until such time as a provider contract is executed by me and Blue Cross and Blue Shield of Massachusetts ("Plan") and I have successfully completed the credentialing or recredentialing process. I also understand that I may not be accepted to participate in the Plan and that misrepresentation or omission of any fact requested will be sufficient cause for immediate, unilateral revocation by the Plan of any participating provider agreement with the Plan.

I understand that the Plan will credential and recredential for Blue Care® Elect. My signature below will serve as a release and waiver to allow the Plan to access relevant information for credentialing and recredentialing purposes.

In making this application, I hereby signify my willingness, if requested, to appear for interviews, authorize representatives of the Plan or their agents (including delegated credentialing entities) to consult with my affiliated hospitals where applicable as well as all other health care facilities, employers, persons or entities with whom I am or have been associated who may have information pertinent to my professional performance, judgment, clinical skills, character, ethical qualifications or any resulting alterations in privileges, mental or physical status, including that I am free of any alcohol or chemical dependency, including but not limited to my malpractice carrier, the National Practitioner Data Bank, and the appropriate Boards of Registration. I consent to the examination of all records of the board and of my primary hospital where applicable and any health care facility at which I have practiced, been employed or had privileges. I further agree to allow the query of my malpractice carrier if necessary.

I release from any liability all representatives of the Plan for their acts performed in good faith in connection with evaluation of my application and my credentials. I release from liability all individuals and organizations who provide information to the Plan in good faith concerning my competence, ethics, character and other qualifications pertaining to the application, including otherwise privileged or confidential information.
I understand and agree that I have the burden to produce adequate information to permit evaluation of my professional competence, character, ethics and other qualifications and for resolving any doubts about such qualifications. I fully understand that this authorization and release extends for a period of the greater of two years or until my next recredentialing cycle.

Additionally, I understand and agree that my complete name and title, specialties, hospital affiliation(s), practice address, gender, education and training, telephone number(s), languages spoken and handicap accessibility at my practice location(s) may be included in a provider directory prepared for prospective enrollees and members should I sign a participating agreement with the Plan.

Photocopies of this document will be as binding as the original. The original signed document must be returned to Blue Cross and Blue Shield of Massachusetts, Inc.

Accepted and agreed to by:

Name (please print):			
Signature:		Date:	
Professional license #:		State where license was issued:	

Please remember to sign and date this document. We cannot process your application without your signature and date.