Blue Shield of California Network Participation Letter of Intent

Thank you for your interest in becoming part of Blue Shield of California's Provider Network. Enclosed, you will find the Blue Shield of California Network Participation Letter of Intent form. The data provided on this form is used by Blue Shield of California (Blue Shield) to determine if the provider group or individual's specialty is eligible for network participation in the region of which its practice is being performed.

Instructions

Identify the provider group or facility requesting network participation and complete all fields with the group/facility/ individual's information. All data elements require provider input. If the data element does not apply, please add "N/A". Once completed please return the application to BSCPrvdrrInformationEnrollment@blueshieldca.com. Please also include a current Service Location and Member Roster with your submission of the Network Participation Letter of Intent. This form (RA form) can be found on the Blue Shield of California Provider Connection website here. Note: Roster Member details are not applicable to the following Ancillary Provider specialty types: Durable Medical Equipment, Orthotics & Prosethics, Ambulance, Dialysis, Home Health, Home Infusion, Clinical Laboratory.

Please note: **this is not a contract** but an application to become in network. Application submission is not a guarantee of participation in our Provider Network. All applications are subject to review. You will receive a written response to your request within approximately 45 business days of receipt.

By submitting this form applicant certifies on behalf of this provider record that all information included on this form is true, accurate and complete. Any false statements, the concealment of material fact, or the use of false documents may lead to prosecution under applicable federal or state laws. Applicant certifies under penalty of perjury that the foregoing is true and correct.

Demographic Information

Individual: DBA should show license name	**Group**		
*Legal entity name: This will be your legal name as listed on your tax document		***SSN/Tax ID:**	
Doing Business As (DBA) name: Check if name is the same as legal entity name		***NPI:**	
*Specialty/Type of Service provided: Primary Care: Yes ☐ No ☐			
*Specialty Comments: please include any additional details related to services provided for reference and consideration to support contracting. For example, DME Providers should include detailed listing of product categories (i.e. respiratory, CGM, Custom Wheelchairs, etc):			
*Primary Address (line 1):			
Address (Line 2): (Suite, Apt, Floor, etc.)	*City:	*State:	*Zip:
*Contact Name: for contract related correspondence	*Email:		

Network Options

* Desired Network Participation

- ☐ Commercial PPO/EPO Standard Network
- ☐ Covered California
- ☐ Medicare Advantage PPO
- ☐ Medicare Advantage HMO
- ☐ Commercial HMO
- ☐ Medi-Cal

Are you currently participating in Medicare?	Yes ☐	No ☐	
Are you currently participating in Medi-Cal or do you wish to participate in Medi-Cal?	Yes ☐	No ☐	
If yes, please include Medi-Cal Orientation Training Attestation Date: _____			
For Medi-Cal providers, are you participating in 'Electronic Visit Verification'?	Yes ☐	No ☐	NA ☐
Are you currently participating in or in a relationship with another entity who is actively in network with Blue Shield of California?	Yes ☐	No ☐	
If you answered yes, please explain?			

Affiliations

Please complete the below if you have indicated a relationship to either a ACS, Hospital, or Facility in which your practice has privileges with. Please note this is for provider groups. For individual Hospital Affiliations please list with roster details.

Hospital Name	ASC Privileges	Effective date

Additional Services Provided

*Are you currently accepting new patients?	Yes ☐	No ☐	N/A ☒
Do you offer advanced access? (same day/next day appt)	Yes ☐	No ☐	N/A ☐
If yes, please explain			
Does your practice offer Urgent Care?	Yes ☐	No ☐	N/A ☐
If yes, please explain			
Does your practice offer walk ins, after hours, or weekends?	Yes ☒	No ☐	N/A ☐
If yes, please explain			
Do you provide gender affirming care?	Yes ☐	No ☐	N/A ☒
If yes, please explain			
Does this provider/group have any special certification and/or expertise?	Yes ☐	No ☐	N/A ☐
If yes, please explain			
Do you perform any specialized or unique procedures/Surgeries/equipment/non-physician services based upon your provider type? (i.e. Transgender surgery)	Yes ☐	No ☐	N/A ☐
If yes, please explain			
If you wish to include any additional information that you feel qualifies you to be in network, please explain and list all relevant details.			

Information Security

Do you or your subcontractor provide any offshore, outside of US 50 states, access to BSC Data?	Yes ☒	No ☐	N/A ☐
If yes, Please state Offshore location(s) (city and country): If yes, is there Secure Virtual Private Network (VPN), Virtual Desktop Infrastructure (VDI), and Multifactor Authentication (MFA) in place when accessing data offshore?			