Individual Practitioner Application Form (RA-01)

The data provided on this form or an additional form with equivalent data is used by Blue Shield of California (Blue Shield) and/or Blue Shield of California Promise Health Plan (Blue Shield Promise) to establish an individual practitioner record for the purpose of supporting claims processing. Blue Shield and/or Blue Shield Promise will confirm eligibility of the applicant for claims submission, using the contact information provided.

Instructions

Identify the practitioner requiring a billing record and complete all fields with the practitioner information. For additional locations, use page three of this document as a template. Attach all required documentation, as outlined below, and return this form to Blue Shield and/or Blue Shield Promise via email at BSCProviderInfo@blueshieldca.com. This form may be completed electronically.

Required Documentation

- Include the licensure/certification or other supporting document(s) for the type of service and name provided:
  - You must indicate the issue date.
  - You must indicate the issuing agency or governing body.
- If you intend to submit claims using a legal entity name filed with the California Secretary of State, submit a copy of the approved filing.
- If you intend to submit claims using an employer identification number (EIN), please submit a signed W-9 or Department of Treasury/Internal Revenue Service (IRS) tax document.

Additional Information

This form is only used to create new individual practitioner records. To update an existing individual practitioner record, please complete the Individual Practitioner Information Change Form (Form ICF-01). This form is not an agreement to participate in the Blue Shield and/or Blue Shield Promise provider network. For information about joining either network, please contact our Provider Information and Enrollment Department via email at BSCProviderInfo@blueshieldca.com

In accordance with regulatory requirements, Blue Shields reports and publishes a maximum number of in-person service locations for practitioners:

Primary Care Physicians (PCPs)
One practitioner may not be listed as a primary care physician (PCP) in more than seven (7) in-person service location addresses across the entire network. This requirement applies even if the practitioner is listed as a PCP on rosters for multiple, separately contracted IPA/medical groups. The aggregated total for providing in-person services as a PCP must not exceed seven (7) service locations in Blue Shield's entire provider directory.

Physician Specialists:
One physician specialist may not be listed as a specialist in more than eleven (11) in-person service location addresses across the entire network. This requirement applies even if the practitioner is listed as a specialist on rosters for multiple, separately contracted IPA/medical groups. The aggregated total for providing in-person services as a specialist must not exceed eleven (11) service locations in Blue Shield's entire provider directory.

The above limitation requirements only apply to in-person service locations for each PCP or specialist practitioner. No limits apply to locations where ONLY telehealth or virtual care services ONLY are provided. If the practitioner also provides services to Blue Shield members in person at the location, however, it will be counted as an in-person services location.

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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.

The practitioner email entered into this form will be tied to your provider portal account notifications and used for account specific outreach. This email address should not be a billing or provider group email address but your individual business email address.

Please type or print information in all fields.

Licensed practitioner's first name, middle name, last name:		National provider identifier (NPI):		
Primary specialty/type of service:		Social security number (SSN):		
Secondary specialty/type of service:		License/certification/permit issuing body:		
License/certification number (attach copy of document)		EIN/TIN (attach pre-printed tax document W-9):		
Practitioner's gender: ☐ Male ☐ Female	Practitioner's ethnicity:	Practitioner's language(s) spoken:		
Hospital affiliation (full hospital name):			Check if practitioner is hospital-based: ☐	
Supervising physician's name (if applicable):		Supervisor's NPI:		
Practitioner's practice website URL:				

Paperless remittance advice (replaces paper EOB)

Direct electronic data interchange (EDI) trading partners may receive 835 electronic remittance advices (ERA) directly from Blue Shield / Blue Shield of California Promise Health Plan.

Authorize a vendor/clearinghouse to receive ERA data to automate your payment posting on your behalf.
This information will certify that the Third Party named below is authorized to receive the provider electronic remittance advice (also known as the 835). Paper Explanation of Benefits will be discontinued at the time of enrollment.

ERA election: ***Select and document only one.*** **The third-party vendor/clearinghouse documented below is authorized to receive ERAs on behalf of the provider**. The trading partner is enrolled to receive ERA via secure file transfer protocol (SFTP) directly from Blue Shield/Blue Shield Promise.

Name:		Street address:		
Phone:	Fax:	City:	State:	ZIP code:
Name of technical contact:		Email address:		

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Service and billing information for location 1							
Practice street address (see page 1 for special instructions):			City:			State:	ZIP code:
Appointment phone number:		Fax number:		After hours phone number (if applicable):			
Individual practitioner business email address:					Wheelchair access? ☐ Yes ☐ No		
Office days and hours:	Sun	Mon	Tues	Wed	Thurs	Fri	Sat
Qualified medical interpreter: ☐ Cantonese ☐ Korean ☐ Mandarin ☐ Russian ☐ Spanish ☐ Vietnamese							
Non-roster member language(s):							
Patient visit options (select all that apply): ☐ Telehealth visits ☐ In-person visits	Gender limitations: ☐ N/A ☐ Male only ☐ Female only		Patient acceptance: ☐ Current patients only ☐ New and existing		Lowest age: Highest age:		
Handicap accessible (select all that apply):							
☐ Exam room	☐ Exterior handicap accessible		☐ Internal handicap accessible		☐ Medical equipment		
☐ Table scale	☐ Parking		☐ Wheelchairs available				
Billing information							
Address if different from service location:			City:			State:	ZIP code:
Phone number:			Fax number:				

Service and billing information for location 2							
Practice street address (see page 1 for special instructions)			City:			State:	ZIP code:
Appointment phone number:		Fax number:		After hours phone number (if applicable):			
Individual practitioner business email address:					Wheelchair access? ☐ Yes ☐ No		
Office days and hours:	Sun	Mon	Tues	Wed	Thurs	Fri	Sat
Qualified medical interpreter: ☐ Cantonese ☐ Korean ☐ Mandarin ☐ Russian ☐ Spanish ☐ Vietnamese							
Non-roster member language(s):							
Patient visit options (select all that apply): ☐ Telehealth visits ☐ In-person visits	Gender limitations: ☐ N/A ☐ Male only ☐ Female only		Patient acceptance: ☐ Current patients only ☐ New and existing		Lowest age: Highest age:		
Handicap accessible (select all that apply):							
☐ Exam room	☐ Exterior handicap accessible		☐ Internal handicap accessible		☐ Medical equipment		
☐ Table scale	☐ Parking		☐ Wheelchairs available				
Billing information							
Address if different from service location:			City:			State:	ZIP code:
Phone number:			Fax number:				