BlueShield of Northeastern New York

Provider Enrollment Form

Provider Name:

Provider Type (MD, DO, NP, PA, etc): Practicing Specialty:

PCP? **YES** ☐ **NO** ☐ Hospital based?: **YES** ☐ **NO** ☐ Is this an Urgent Care Facility? **YES** ☐ **NO** ☐

NYS License #: DOB:

Sponsoring Physician name for NP, PA, CRNA, CNM:

CAQH #: Tax ID#: Individual NPI#:

Group Name: Group NPI#:

Par with Medicare: **YES** ☐ **NO** ☐ Has provider opted out of Medicare? **YES** ☐ **NO** ☐

Physician Primary Hospital Affiliation: Is the provider Board Certified? **YES** ☐ **NO** ☐

Par with Medicaid: **YES** ☐ **NO** ☐ if yes, Medicaid Number:

PRACTICE LOCATION/PHONE/COUNTY:

1) _____

2) _____

* ATTACH ADDITIONAL LOCATIONS*

Inpatient: **YES** ☐ **NO** ☐ Skilled Nursing Facility: **YES** ☐ **NO** ☐

Is the hospital that your clinic is affiliated with accredited by any of the following organizations:?

JCAHO ☐ DNV ☐ CIHQ ☐ AOA/HFAP ☐ N/A ☐

Det Norske Veritas Health Care — Center for Improvement in Healthcare Quality — American Osteopathic Association/Healthcare Facilities Accreditation Program

Can members schedule appointments with this provider at these locations? **YES** ☐ **NO** ☐

Credentialing Contact Name:

Credentialing Contact Phone: Email:

NOTE: *As of August 1, 2009 all Provider's must be on-line with CAQH. If you have not signed up, please sign up with CAQH before submitting this form. Thank you!*

Fax the completed form to:

7168872056