Urgent Care Center Application Questionnaire

Complete this form to be considered for participation in our provider network(s).

Please attach the following: **W-9, Accreditation, Completed RFI Document**

General Information

Group Name	
Service Specialty: Urgent Care Center	Provider Type: Urgent Care
Tax Identification	Billing NPI (Type 2)

Authorized Office Manager/Contact Person

First Name	Job Title
	Last Name
Phone Number Extn	Email Address

Accreditation Body

Accred Body	Effective Date	Expiration Date

Licenses

License Name	State	Date of Issuance

Insurance

Insurance Name	Policy Number	Coverage Type Aggregate	
Occurrence Amt	Aggregate Amt	Effective Date	Expiration Date

Tax Address (to receive 1099 form)

Street Address		Telephone Number	
City	State	County	Zip Code

Mailing Address (to receive claim forms, publications and other correspondence)

Street Address		Telephone Number	
City	State	County	Zip Code

Payment Address, if different from above (to receive reimbursement checks)

Street Address		Office Telephone Number	
City	State	County	Zip Code

Service Location

Street Address		Primary Location? ☐ Yes ☐ No	Effective Date
		Location Telephone Number	
City	State	County	Zip Code

Additional Locations

Service Location (Secondary)			Effective Date
Street Address		Location Telephone Number	
City	State	County	Zip Code

Service Location (Secondary)			Effective Date
Street Address		Location Telephone Number	
City	State	County	Zip Code

Service Location (Secondary)			Effective Date
Street Address		Location Telephone Number	
City	State	County	Zip Code

Service Location (Secondary)			Effective Date
Street Address		Location Telephone Number	
City	State	County	Zip Code

Service Location (Secondary)			Effective Date
Street Address		Location Telephone Number	
City	State	County	Zip Code

Request for Information (RFI) Application

CareFirst Family of health care plans

INSTRUCTIONS

Designed for ancillary and hospital providers to apply for participation in the CareFirst BlueCross BlueShield and/or CareFirst BlueChoice, Inc. (CareFirst) networks for services rendered in the CareFirst service area of Maryland, Washington, D.C, and Northern Virginia.

- Type or print all sections of this form. Responses may be supported by attachments. If a question or entire section does not apply to your organization, **indicate N/A**.
- Failure to complete all sections, or indicate N/A when the requested information does not apply, may delay processing.
- Email addresses must be provided as electronic communication is required for parts of the CareFirst service area.

Submit form to: CareFirst BlueCross BlueShield and CareFirst BlueChoice, Inc., Institutional Contracting, Mailstop CG-51, 10455 Mill Run Circle, Owings Mills, MD 21117, Phone: 410-872-3526, Fax: 410-505-2765.

PROVIDER INFORMATION

Legal Name of Provider (as registered with IRS and listed on IRS Form W-9 Request for Taxpayer Identification Number and Certification. Please include dba, if applicable.)

Do you currently participate with CareFirst under another provider name?

○ Yes ◉ No

If yes, please indicate the provider name and tax identification number.

Would you like the legal name printed above to appear as listed in our participating provider directories?

○ Yes ◉ No

If no, please print provider name as you want it to appear in our participating provider directories and attach corresponding W-9 form.

Is the Organization Incorporated? ○ Yes ○ No If yes, list below status of incorporation.	Effective Date of Corporation

AGREEMENT CONTACT INFORMATION

Who will be signing the Agreements?

Name	Title

Agreement Mailing Address (P.O. Box is not acceptable)

Street	City	State	Zip (plus four)

Email Address to Send Agreements for Signature

LEGAL NOTICES INFORMATION

Who will receive any legal notices?

Name	Title

Legal Notices Mailing Address (P.O. Box is not acceptable)

Street	City	State	Zip (plus four)

Phone	Email Address of Contact for Contract Updates or Notifications

CREDENTIALING CONTACT INFORMATION

Who will be the credentialing point of contact for your practice?

Name	Title

Credentialing Mailing Address (P.O. Box is not acceptable)

Street	City	State	Zip (plus four)

Credentialing Email Address	Credentialing Phone #	Credentialing Fax #

DIRECTORY INFORMATION

Directory Address (If additional directory addresses or locations are applicable, you must complete a separate RFI for each location. P.O. Box is not acceptable.)

Street	City	State	Zip (plus four)

Patient Appointment Telephone #	Office Manager Name

Office Manager Telephone #	Office Manager Email

BILLING INFORMATION

Billing Entity Name	Billing Contact

Billing Contact Telephone #	Billing Contact Email Address

Street	City	State	Zip (plus four)

PAYEE INFORMATION

Payee Name	Payee Contact

Payee Telephone #	Payee Email Address

Payee Address

GENERAL INFORMATION

List hours of operation	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

Please list your local service area	County	Areas/Towns

Please list the types of services you provide to your patients and patrons. (DME providers please specify type of equipment supplied; i.e. crutches, walkers, oxygen, diabetic supplies, etc.).

If applicant answers Yes to any of the below questions, please attach an explanation.

1. Has the applicant ever been expelled or suspended from receiving payment under Medicare, Medicaid or any other type of insurance program?	○ Yes ○ No
2. Has the applicant ever been censured, placed on probation, had their license, certificate or permit suspended or revoked by any licensing or accrediting authority?	○ Yes ○ No
3. Has the participation in any managed care or indemnity services provider network ever been revoked, suspended or sanctioned?	○ Yes ○ No
4. Has the applicant been named in any professional liability action which resulted in a settlement or judgment against the applicant?	○ Yes ○ No

1099 INFORMATION

Attach a copy of IRS Form W-9 Request for Taxpayer Identification Number and Certification, NPI documentation and email confirmation from NPPES.

Period Covered	Medicare Provider #	NPI #

LIABILITY INSURANCE

Attach a copy of the policy and any riders.

Carrier	Coverage Amount Per Occurrence
Expiration Date	Coverage Amount Aggregate

LICENSING AND APPROVAL LICENSURE

Attach a copy of all licenses listed below.

License #	State	Date of Issuance
License #	State	Date of Issuance
License #	State	Date of Issuance

Have licensure requirements been waived by virtue of deemed status?

○ Yes ○ No

If yes, please indicate the organization through which the applicant has deemed status:

If a VA or D.C. based provider, has the applicant obtained a certificate of need (CON)?

○ Yes ○ No

If yes, what geographical area does the CON authorize the applicant to serve (by county and town):

ACCREDITATION/CERTIFICATION

Please submit copies of all licenses, operating certificates and correspondences regarding accreditations and approvals, including survey reports.

Accrediting/Certifying Body

Accreditation/Certification	Yes	No*	Period Covered	Survey Schedule Date
Medicare	○	○		
The Joint Commission (TJC)	○	○		
Other(s): (specify)	○	○		

* If the applicant has not yet applied for accreditation, please describe any plans to seek accreditation, from which accrediting body and under what timetable.

If Medicare certified, indicate for which specialty areas certification is held and the Medicare number. Include a copy of the notification from Medicare.

OWNERSHIP, GOVERNANCE AND MANAGEMENT

Attach a copy of all licenses listed below organizational ownership, governance and management.

Ownership	Yes	No
For-Profit Entity	○	○
Private Corporation	○	○
Subsidiary of the Above	○	○
Non-Profit Entity	○	○
Other (specify)	○	○

Is any part of your practice/organization hospital affiliated or based? ○ Yes ○ No

If yes, supply the name and location of the hospital(s) and privileged services authorized by the hospital(s):

Please list all parent or sponsoring organizations, including all organizations/individuals with more than 10% of ownership participation and any arrangements the applicant has with physicians or other provider entities, including but not limited to joint ventures etc.

DURABLE MEDICAL EQUIPMENT PROVIDERS

(Note: CareFirst is not accepting additional Durable Medical Equipment (DME) providers for Sleep Apnea (CPAP) equipment and supplies. If you offer other DME you can proceed with a request for participation for those DME items.)

Do you ever need to enter a patients home when providing any DME services or equipment? ○ Yes ○ No

AMBULATORY SURGERY CENTERS (ASC)

ALL ANESTHESIA, RADIOLOGY, PATHOLOGY AND LAB PROVIDERS WHO RENDER SERVICES AT/FOR THE SURGERY CENTER MUST BE CONTRACTED WITH CAREFIRST PRIOR TO THE SURGERY CENTER'S APPROVAL FOR PARTICIPATION.

Please list Specialty(s)

Please define the facility classification by indicating YES or NO	**Yes**	**No**
Class A (Local or No Anesthesia)	○	○
Class B (Local with IV Sedation)	○	○
Class C (Deep Sedation, General Anesthesia)	○	○
Does ASC employ the following facility-based physicians: Anesthesiologists, Radiologists and/or Pathologists?	○	○

If yes, state Physician's Name(s) and current Tax Identification Number for each. If services are out-sourced to a vendor, please list vendor name(s) and Tax Identification Number(s).

Anesthesiologists	Tax ID
Pathologists	Tax ID
Radiologists	Tax ID
Lab	Tax ID

Please list all other providers who render services at this facility. (If needed, please attach list to this RFI.) CareFirst participation is preferred, but **NOT** required for the physicians listed below.

Name	Tax ID
Name	Tax ID
Name	Tax ID

If your ASC is located in Virginia and is not licensed, please complete and email a list of CPT codes for all services rendered at your facility as an excel document (or similar file format) to Jackie Redmond.

SIGNATURE

The information included in this application will be utilized by CareFirst solely for its own purposes and will not be disclosed to others except as required for the purpose of verification.

- I hereby certify that the statements and answers provided herein are complete and correct to the best of my knowledge and belief and have been made for the purpose of applying to become or continuing as a participating provider.
- I authorize CareFirst to verify any and all of the above information.

Name (please print)	
Title	
Signature	
Date	
Telephone #	

Race and Ethnicity

CareFirst does not discriminate or base credentialing decisions on an applicant's race, ethnicity or language, and providing the information is optional.

Race: Please select the applicable value.

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Hispanic or Latino
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White
- ☐ Black or African American
- ☐ Middle Eastern or North African
- ☐ Prefer not to answer
- ☐ Unknown

Ethnicity: Please select the applicable value.

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Prefer not to answer
- ☐ Unknown