

Professional Provider Application

TO PREVENT THE APPLICATION PROCESS FROM STOPPING, COMPLETE THE SECTIONS APPROPRIATE TO YOUR SITUATION

Complete the South Dakota Uniform Application if you are interested in contracting with any Wellmark network for the first time.

Please check the appropriate box below. I am completing this application because:

- I want to submit claims and not contract with Wellmark. *Complete Sections A and D.*
- I am adding an emergency room location. *Complete Sections A, B and D.*
- I am adding a new practice location for a Wellmark and/or TRICARE provider network. *Complete the entire application.*

Section A. COMPLETE IF SUBMITTING CLAIMS, ADDING AN ER OR OFFICE SITE

1. Individual Provider Information

Legal Name (last, first, middle) _____

Title/Degree _____

Date of Birth (mmddyyyy) _____ Gender Male Female

Primary Specialty (or field of practice) _____

Secondary Specialty(ies) _____

If your specialty is family or general practice or internal medicine, do you provide obstetrical care?

Yes No

2. Practice Location (for which you are applying)

Location Name _____

Street Address _____ Location Phone (____) _____ - _____

City, State, Zip+ _____ County _____

Scheduling Phone (____) _____ - _____ Fax Number (____) _____ - _____

Would you like a billing number for this location? Yes No

3. Accounting Location (Billing address if different from #2.)

Office/Clinic Name _____

Street Address _____

City, State, Zip+ _____ Accounting Location Phone (____) _____ - _____

4. Effective Date at this location (date to coincide with claim submission - mmddyyyy): _____

5. Identification Numbers (Complete the attached W-9 form and return it with this application.)

Federal Tax ID# _____ Social Security # _____

UPIN # _____ Medicare # _____

Individual NPI#: _____ Group/Organization NPI# _____

6. Licensure

a. Your name as it appears on current license: _____

b. Current / Previous licenses: (list all states and countries which you currently or previously been licensed).

Issuing State/Country	Issue Date	License Number	Expiration Date
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

7. Controlled Substance

Federal Drug Enforcement Agency (DEA) Registration Number (if applicable) _____

Section B. COMPLETE ONLY IF ADDING AN ER OR OFFICE SITE

1. **Wellmark Networks** - Please indicate the networks in which you or your group currently participate:
 Classic Blue Blue Select Select First TRICARE
 Blue Access, Blue Choice, Blue Advantage Medicare Advantage
2. **Specialty Certification** - Check all that apply, if applicable
 Board Certified - Name of Board(s) _____ Date of Certification (mm/yy) _____ Expiration Date (mm/yy) _____

 Board Eligible - Name of Certifying Board _____ Year Eligibility Terminates _____
3. **Professional Liability Coverage** - Please list below your professional liability carrier and the dates of coverage to include month, day and year of beginning coverage and expiration date. If your practice start date is in the future, please include **current** professional liability carrier information on page 4 (Additional Information).
Carrier Name _____
City / State _____
\$ Amounts: Per Occurrence _____ \$ Amounts: Aggregate _____
Date from (mmdyyy) _____ Date to (mmdyyy) _____
4. Do you presently have a physical, mental or emotional condition (including alcohol or drug dependence) that affects or is reasonably likely to affect your ability to perform your professional duties appropriately or which could adversely affect the quality of care rendered to your patients or jeopardize the safety of patients? Yes No
If the answer is yes, please explain on page 4 (Additional Information).

Section C. COMPLETE ONLY IF ADDING AN OFFICE SITE

1. **Practice Arrangement** (at each practice location)
a. Solo Partner/Associate Resident/Fellowship Group/ Clinic Employee
 Locum Tenens (from / to) _____ Other _____
b. Do you practice at this location as a: Primary Care Provider (PCP) Ob-Gyn Provider Specialist
2. **Foreign language**
What foreign language(s) do you speak? _____
3. **Hospital Privileges** - List additional current hospital privileges and staff status on page 4 (Additional Information).
Primary Hospital _____
City, State _____
Staff Status Admitting Pending Other (specify) _____
Other Hospital _____
City, State _____
Staff Status Admitting Pending Other (specify) _____
If you don't currently have hospital privileges, please explain what arrangements have been made to provide your patients access to inpatient care when necessary. Include the name of the physician who has agreed to coordinate care.

4. **Practice Information** (for each practice location)
a. Primary Care Provider (PCP) OB-Gyn Provider Specialist PCP Back-up Only
 Both PCP & Specialist (must provide primary and secondary specialty for separate listings in directory)
- b. Are you (the application practitioner) accepting new patients? Yes No
c. Are other practitioners in your group accepting new patients? Yes No
d. Are you continuing to accept current patients if they change insurance plans? Yes No

e. Identify your practice limitations on patients (age, gender, payor, scope of practice), if any. _____

**COMPLETE BELOW ONLY IF APPLYING FOR
BLUE ACCESS, BLUE CHOICE, BLUE ADVANTAGE**

Providers only eligible if practice in Lincoln, Minnehaha and Union counties

5. Reimbursement Choice (PCPs only)

Blue Choice and Blue Advantage offer PCPs the opportunity to be paid either capitation or fee for service. Please indicate which payment option you are currently accepting. Your selection applies to all capitated products under this tax identification number.

- Capitation on primary medical/surgical services
 Fee-for-service

6. Back-Up Physician Information

If you are applying for managed care networks, (i.e.: Blue Access, Blue Choice, Blue Advantage) you must designate a back-up. If your back-up arrangements are unique to a specific location, photocopy this page and submit a page for each location.

a. Do you and your designated back-up provider(s) bill Wellmark using a group identification number?

- No (Complete letter 'b' below)
 Yes (List group number and address. Complete letter 'b' below if applicable):

Group Provider Identification #/ NPI#: _____

Location Address: _____

b. If you do not bill Wellmark as a group OR your designated back-up(s) include providers outside of your group provider number, **please list the name, complete address, specialty, effective date and provider ID or NPI number of each individual providing back-up coverage for you.** Please indicate this information for each site on this application (*use the additional information section of this application, if needed*).

Name: _____ Specialty: _____

Complete Address: _____

Effective Date: _____ Provider ID#/NPI#: _____

Name: _____ Specialty: _____

Complete Address: _____

Effective Date: _____ Provider ID#/NPI#: _____

Name: _____ Specialty: _____

Complete Address: _____

Effective Date: _____ Provider ID#/NPI#: _____

c. Do you provide back-up coverage for the provider(s) you indicated as your back-ups? Yes No
(Please complete the information below.)

Name: _____ Specialty: _____

Complete Address: _____

Effective Date: _____ Provider ID#/NPI#: _____

Name: _____ Specialty: _____

Complete Address: _____

Effective Date: _____ Provider ID#/NPI#: _____

Name: _____ Specialty: _____

Complete Address: _____

Effective Date: _____ Provider ID#/NPI#: _____

Section D. ALL PRACTITIONERS MUST COMPLETE

Please do not backdate. Application will be returned if signature date is *older than 60 days*

Confirmation of Practitioner Enrollment

For an electronic summary of the practitioner’s network participation status resulting from this application, complete the following fields. If you would like others to receive this information, such as billing staff, include e-mail addresses on the lines provided.

Primary Contact _____

Primary Contact Phone Number _____

Primary Contact E-mail Address _____

Other E-mail Address(es) _____

Note: If a contract is being signed as part of this application process, this option is not available. Contract(s) and participation status will be sent by mail.

Clinic Authorization and Agreement

Complete (1) *ONLY* if your services are billed under a group number. Complete (2) if application was not completed by provider. All providers need to complete (3).

(1) Wellmark Blue Cross and Blue Shield of South Dakota Clinic Authorization and Agreement

I authorize Wellmark Blue Cross and Blue Shield of South Dakota, its subsidiaries and affiliates to make any payment to:

→ _____
Clinic Name Street Address City

for services that I perform. I agree that charges for my services will be uniform with all other physicians or health care providers that practice in the clinic named above.

→ _____
Practitioner’s Signature Date Signed

Certification and Release

(2) Certification and Release of the individual preparing the application. This section is to be completed if this application has been prepared by someone other than the provider.

I, _____, hereby attest that the information included on this application is

Preparer’s Name
accurate, true, complete and can be retrieved from the files located at:

→ _____
Clinic Name Street Address City Phone Number

→ _____
Preparer’s Signature Date Signed

(3) Certification and Release for provider.

I understand that any information entered on this application that subsequently is found to be false could result in immediate dismissal from any Wellmark Blue Cross and Blue Shield of South Dakota program.

I hereby certify that the information contained in this application is accurate, true and complete. I authorize release of information as may be required by Wellmark Blue Cross and Blue Shield of South Dakota to process this application. My signature on this application does not constitute a contract with Wellmark Blue Cross and Blue Shield of South Dakota. By signing this application, I authorize Wellmark Blue Cross and Blue Shield of South Dakota to release this information to Wellmark of South Dakota, Inc. subsidiaries and affiliates.

→ _____
Signature of Physician or Health Care Provider Date Signed

