



# Professional Provider Application

Wellmark Blue Cross Blue Shield of Iowa  
Wellmark Health Plan of Iowa, Inc.

Independent Licensees of the Blue Cross and  
Blue Shield Association

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

Complete the Statewide 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.*
- I am adding Wellmark's traditional, Alliance Select and/or Select First network(s) to my current practice location. *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+4 \_\_\_\_\_ County \_\_\_\_\_  
 Scheduling Phone (\_\_\_\_\_) \_\_\_\_\_ Fax Number (\_\_\_\_\_) \_\_\_\_\_

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

Office/Clinic Name \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City, State, Zip+4 \_\_\_\_\_ 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 in 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 are or previously have been licensed)

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

#### 7. Controlled Substance

Federal Drug Enforcement Agency (DEA) Registration Number (if applicable) \_\_\_\_\_

#### 8. Psychologist Only

a. Are you listed in the National Registry of Health Service Providers in Psychology (HSPP)?  Yes  No

b. National Registry HSP Number \_\_\_\_\_  
 Date of Certification \_\_\_\_/\_\_\_\_/\_\_\_\_ Expiration Date \_\_\_\_/\_\_\_\_/\_\_\_\_

c. Iowa HSP Number \_\_\_\_\_  
 Date of Certification \_\_\_\_/\_\_\_\_/\_\_\_\_ Expiration Date \_\_\_\_/\_\_\_\_/\_\_\_\_

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

- Wellmark Networks** - Please indicate the networks in which you or your group currently participate:  
 Classic Blue®                       Alliance Select<sup>SM</sup>                       Select First®                       TRICARE  
 Blue Access®, Blue Choice®, Blue Advantage® - Universal                       Medicare Advantage
- 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 \_\_\_\_\_
- 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) \_\_\_\_\_
- 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**

- 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
- Foreign language**  
 What foreign language(s) do you speak? \_\_\_\_\_
- 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.  
 \_\_\_\_\_  
 \_\_\_\_\_
- 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 applying 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

5. **Reimbursement Choice (PCPs Only)**

Blue Choice and Blue Advantage offer PCPs the opportunity to be paid either capitation or fee of service. Please indicate which payment option you are currently accepting. Your selection applies to all capitated WHPI 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 ID#/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

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# \_\_\_\_\_



