Dual Line of Business
Individual Credentialing Intake Form

This intake form is intended for individuals who are joining with **existing** Blue Shield of California (Blue Shield) Medicare, Commercial, and/or Blue Shield Promise Medi-Cal contracts and for providers wishing to join new/pending Medicare and/or Commercial contracts.

For net new or pending Medi-Cal contract negotiations please submit a letter of interest via email to promiseloi@blueshieldca.com.

Contract Information:	
Requested Line of Business:	**Blue Shield of California:** ☐ **Medicare** ☐ **Commercial** ☐ **TriWest** **Blue Shield Promise:** ☐ **Medi-Cal (Requires existing Medi-Cal contract)**
Contract Status:	☐ **Contract Established/Existing:** Group or practitioner holds a fully executed provider agreement with commercial, Medicare and/or Medi-Cal lines of business. ☐ **Contract Pending (Blue Shield only):** Group or practitioner is in negotiations with commercial and/or Medicare lines of business. • Please do not select this option if you are a net new or pending Medi-Cal contract, if you do so the application will be cancelled. In order to apply for a new contract with Promise Health Plan, you will need to reach out to the above mentioned promiseloi@blueshieldca.com email address.
	Contract Entity Name: **Contract Entity Tax ID:** **Contract Entity NPI:**
Individual Practitioner/Provider Information:	
Practitioner Information:	**Name:**
	Medical License Number:
	Date of Birth:
	NPI:
Application Type: **(select one)**	☐ **CAQH – CAQH Number Required:** ☐ **CPPA, NPMP, or AHPA – PDF of application required**
Provider Type:	☐ **Primary Care Physician (PCP)** ☐ **Specialist** ☐ **Mid-Level** ☐ **Hospitalist** ☐ **Urgent Care Specialist** ☐ **Behavioral Health (BH)** ☐ **Telehealth** ☐ **Mental Health/Substance Use Disorder (MH/SUD)** ☐ **Other (please indicate):**
	Primary Specialty:

Requested Contract Specialty:	**Secondary Specialty:**
Office Location and Contact Information:	
Physical Location Information:	**Street Address:** **City, State, Zip:** **Phone #:** **Fax #:** **Email:**
	Manager Name: **Manager Email:** **Phone #:**
Credentialing Contact Information:	**Name:** **Email:** **Phone #:**
	Mailing Address of notice (if different from physical location):
Supporting Documentation:	
Please include copies of the attached, if applicable:	☐ CPPA, NPMP, or AHPA, if applicable ☐ Curriculum Vitae/Resume ☐ Malpractice insurance certificate, $1M per occurrence & $3M aggregate (must be current) or as applicable based on provider type. ☐ Mid-Level Delegation Agreement, if applicable ☐ Covering Physician Agreement, if applicable • Covering Physician required for applicants that require a covering physician for hospital privileges and/or DEA. **For Blue Shield Promise Medi-Cal applicants only:** • If applying as a PCP has the practice location had a recent Facility Site Review within the last 3 years. ☐ Yes ☐ No • ☐ Medi-Cal Acceptance Letter, if available. Please note the credentialing department validates Medi-Cal enrollment via California Health and Human Services Open Data Portal. If the provider cannot be validated via the portal, a Medi-Cal acceptance letter may be required.