RESET

Horizon Blue Cross Blue Shield of New Jersey

Three Penn Plaza East
Newark, NJ 07105-2200
HorizonBlue.com

OTHER HEALTH CARE PROFESSIONAL CHECKLIST

Thank you for your interest in joining the Horizon Managed Care Network and/or the Horizon PPO Network.

This form applies to, and should be completed by Acupuncturists, Advanced Practice Nurses, Audiologists, Behavioral Health Practitioners (other than Psychiatrists), Certified Nurse Midwives, Certified Nurse Practitioners, Certified Registered Nurse Anesthetists, Chiropractors, Physical, Occupational and Speech Therapists, Optometrists, Physician Assistants, Podiatrists OR Registered Dieticians who are interested in joining the Horizon Managed Care Network and/or the Horizon PPO Network.

In order for us to assess your credentials and ensure that you meet all criteria for participation, please complete this form and mail it along with ALL other items outlined here (as applicable) to:

Horizon BCBSNJ
Credentialing & Recredentialing Department
3 Penn Plaza East, PP-14C
Newark, NJ 07105-2200

A. OTHER HEALTH CARE PROFESSIONAL INFORMATION

_____ _____
Practitioner name *(please print clearly)* County in which your practice is located

_____ _____/_____/_____
CAQH# Date of Birth *(required to access CAQH information)*

I am seeking participation in the: ☐ Horizon PPO Network ☐ Horizon Managed Care Network

B. CREDENTIALING/RECREDENTIALING CONTACT

Please provide contact information of the person(s) at your practice who Horizon BCBSNJ can work with to address any credentialing and recredentialing questions/requests.

_____ _____
Contact 1 Name Contact 1 Title

_____ _____
Contact 1 Phone Contact 1 Email

_____ _____
Contact 2 Name Contact 2 Title

_____ _____
Contact 2 Phone Contact 2 Email

32244 (W0718)

C. CREDENTIALING INFORMATION

Please complete/provide the information requested below so that we may assess your credentials for participation in our network(s).

- If you are using the **CAQH ProView™** to make information available to us for credentialing, please complete/provide only items #1 through 4 in this section.
- If you are not using the **CAQH ProView** , please complete/provide items #1 through 11 in this section.

1. Signed Agreement(s)

Please review, complete and sign the appropriate Agreements for the network(s) in which you are seeking participation.

☐ HEALTHCARE OF NEW JERSEY, INC. AGREEMENT WITH PARTICIPATING PHYSICIANS AND OTHER HEALTHCARE PROFESSIONALS for participation in the Horizon Managed Care Network.

☐ AGREEMENT WITH PARTICIPATING PHYSICIANS AND HEALTHCARE PROFESSIONALS for participation in the Horizon PPO Network.

Copies of our Agreements are available online to registered NaviNet users. Log in to NaviNet and from the *Horizon BCBSNJ* plan central page:

- Mouse over *References and Resources* and click *Provider Reference Materials.*
- Mouse over *Resources,* click *Manuals & User Guides,* and then click *Agreements*.

If you don't have NaviNet access, please call **1-800-624-1110** to request an application.

Please follow the instructions provided with each Agreement.

- Do not highlight, cross out, use white out on, or alter any content in the Agreement(s).
- Ensure that the Agreements reviewed and completed are the current online versions.
- Fully spell out your specialty. Do not abbreviate.
- Sign in the designated areas only.
- Do not date section 16 of the Horizon Managed Care Network Agreement. This information will be added following the completion of the credentialing process.

Upon completion of the credentialing process, countersigned Agreement(s) will be returned to you for your records.

2. Statement of Collaboration

☐ Certified Nurse Midwives, Certified Nurse Practitioners, Certified Registered Nurse Anesthetists, and Physician Assistants must establish a consultative, collaborative management and referral relationship with an appropriate Horizon BCBSNJ participating physician and have our **Statement of Collaboration** form completed and signed. This form must be signed and dated within 180 days of the submission date.

3. Curriculum Vitae

☐ Please provide a Curriculum Vitae, organized by month/year, outlining your work history from your formal training to the present. Please explain any gaps in work history of greater than six months.

4. Provider Network Special Needs Survey

☐ Please provide a completed copy of our **Provider Network Special Needs Survey**.

C. CREDENTIALING INFORMATION *(CONTINUED)*

If you are **not** using the **CAQH ProView**, please also complete/provide the following.

5. ☐ A completed copy of the **N.J. Universal Physician Application**. Please note that paper applications take significantly longer to process.

6. ☐ Explanations of all **"Yes"** answers to questions on the N.J. Universal Physician Application concerning malpractice cases, suspension of license, etc.

7. ☐ A copy of your current state medical license.

8. ☐ A copy of your current New Jersey CDS (if applicable).

9. ☐ A copy of your current DEA Certificate for the State in which you practice (if applicable).

10. ☐ Proof of Board Certification or documentation showing formal training was completed with the last five years (if applicable).

11. ☐ Current malpractice insurance certificate face sheet from a carrier authorized to issue policies in the State of New Jersey. The face sheet must display your name, the effective dates of the policy, and the coverage limits. A minimum of $1 million per occurrence and $3 million aggregate is required. Pennsylvania providers require additional coverage of $500,000 to $1.5 million on malpractice facesheet.

D. PRACTICE-LEVEL INFORMATION

Please provide the following information pertaining to the office location(s) at which you are or will be practicing.

1. Practice Demographic Updates Contact

Please provide contact information for the person at your practice who Horizon BCBSNJ can work with to address questions about practice demographic information and updates.

Contact Name:_____ Contact Title:_____

Contact Phone:_____ Contact Email:_____

2. Americans with Disabilities ACT (ADA) Provider Survey

☐ Please provide a completed copy of the **Americans with Disabilities ACT (ADA) Provider Survey** for each office location at which you (will) practice.

This information only needs to be submitted once per practice location. If you're joining a participating practice check with your office manager to see if this information has already been submitted.

3. Clinical Laboratory Improvement Amendment certificate (CLIA)

☐ Please respond to the following question and provide information, as appropriate, regarding **CLIA Certification** for each office location at which you (will) practice.

Are onsite clinical laboratory services provided at any office locations at which you practice? ☐ Yes ☐ No

If you responded **"Yes"**, please provide the ten-digit CLIA identification number for <u>each</u> office location as appropriate:

_____

_____

Please also provide a copy of the CLIA Certificate for <u>each</u> location as appropriate.

This information only needs to be submitted once per practice location. If you're joining a participating practice check with your office manager to see if this information has already been submitted.