Horizon

RESET

Participation Application for Telemedicine-Only Practitioners

Thank you for your interest in joining the Horizon's Managed Care Network, PPO Network and/or the Horizon NJ Health networks. This application applies to, and should be completed by, nonparticipating practitioners who will provide ONLY TELEMEDICINE services to members enrolled in Horizon BCBSNJ or Horizon NJ Health plans or products.

Telemedicine is the delivery of healthcare services using HIPAA compliant and secure electronic communications, information technology, or other electronic or technological means to bridge the gap between a health care provider who is located at a distant site and a patient who is located at an originating site, either with or without the assistance of an intervening health care provider for the purpose of diagnosis, consultation, and/or treatment of a patient.

We encourage you to review our Horizon BCBSNJ Telemedicine Services reimbursement policy and our Horizon NJ Health Telemedicine and Telehealth reimbursement policy.

To participate with Horizon NJ Health, you must be licensed and located within New Jersey.

To participate with Horizon BCBSNJ, you must be licensed in New Jersey, Delaware, New York or Pennsylvania and have a physical location in one of the counties within the Horizon BCBSNJ local service area. Our local service area includes: all counties in New Jersey; Kent, New Castle or Sussex County, Delaware; Bronx, Kings, New York, Orange, Richmond, Rockland or Westchester County, New York; Bucks, Delaware, Monroe, Northampton, Philadelphia, Lehigh or Pike County, Pennsylvania.

Credentialing Process Overview

Below is an overview of what you need to do and what you can expect from us as you proceed through our initial credentialing process.

1 So that we may assess your credentials and ensure that you meet the criteria for participation in our network(s), please complete the information on the following pages, as appropriate and gather copies of all documentation requested, as appropriate (including signed Agreements).

- Complete all fields, as appropriate, on this application.
- Provide a **Curriculum Vitae** (CV), 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. In the absence of a CV, please complete the Medical Education fields below beginning on page 7.
- Provide information about your **Professional Liability Insurance Coverage** on page 8.
- Complete the fields within the **Special Needs Information** section beginning on page 9. This information helps us understand your training and/or experience treating patients with special needs.
- Complete the fields within the **Areas of Expertise** section beginning on page 11. Please note that there are two separate Areas of Expertise sections: one for medical practitioners and one for behavioral health practitioners.
- Complete the **Telemedicine Services Attestation** on page 13 if you provide telemedicine services.
- Complete the fields within the **MAT/OBAT and Navigators Attestations** section beginning on page 13 if you provide MAT or OBAT services.
- Review the **Signed Agreements** information on page 16. Please access, review, complete and sign the appropriate Agreement version(s) for the network(s) in which you are seeking to participate.

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- Complete the **Disclosure Questions** beginning on page 18. Please provide explanations of your responses, as appropriate, in the space provided. If more space is needed, please include a separate document with the full explanation.
- Complete the **Attestation** on page 25. By signing this section you attest that the answers provided and the information submitted is true, complete and correct.
- Gather copies of the following documentation to be submitted along with this Application.
  - ☐ A copy of your current state medical license.
  - ☐ A copy of your current New Jersey Controlled Dangerous Substance (CDS) Certificate (if applicable).
  - ☐ A copy of your current DEA Certificate for the State in which you practice (if applicable).
  - ☐ Proof of Board Certification or documentation showing formal training was completed with the last five years.
  - ☐ A copy of your current malpractice insurance certificate face sheet from a carrier authorized to issue policies for the state in which your primary office is located. The face sheet must display your name, the effective date of the policy, expiration date and the coverage limits. A minimum of $1 million per occurrence and $3 million aggregate is required.
  - ☐ W-9 information for each location at which you are or will be practicing.
  - ☐ A copy of the NPPES NPI Registry's Provider Information screen for each practice at which you are or will be practicing.

Please note that practitioners seeking to participate with our Horizon NJ Health network must register with the State of New Jersey under the 21st Century Cures Act. Visit our 21st Century Cures Act webpage for information about this requirement as well as details about how to register with the State of New Jersey.

2 Please mail your completed package of information to the address below.

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

For the duration of the COVID-19 public health emergency, you may also email your completed Application package to EnterprisePDM@horizonblue.com.

If you are mailing information for more than one practitioner within a single envelope/package, please ensure that the documentation is organized and separated by practitioner.

If you are emailing information for more than one practitioner, please submit one email per practitioner.

3 Our Credentialing Department will send a written notice to advise you that we received sufficient information to begin our credentialing process.

- If all required information/supporting documentation is not included, your Application will be withdrawn and a new Application (inclusive of all documentation originally submitted) will be required.
- Applications for a *future* practice location (greater than 90 days from our credentialing date) will be withdrawn.

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4 Our credentialing process takes approximately **45 to 90 days** from the date that we have all required information.

- We will send you a written response if your Application has been approved or denied.
- If you have not received a written response about your Application after 90 days, you may call **1-800-624-1110** for the status of Horizon BCBSNJ Applications or email an inquiry to PCS_Credentialing_Mailbox@horizonblue.com for the status of Horizon NJ Health Applications.

5 Once approved by the Horizon BCBSNJ Credentialing Committee, we will send a letter that includes:

- Your participation effective date
- Instructions to access a welcome kit of important information
- Copies of your fully executed Agreement(s)

If you have questions about the credentialing process

- Please call Horizon BCBSNJ at **1-800-624-1110**
- Please email Horizon NJ Health at PCS_Credentialing_Mailbox@horizonblue.com

CONTACT PERSON FOR CREDENTIALING/RECREDENTIALING

Please provide information about a contact person who we can reach to discuss questions concerns about initial credentialing and recredentialing.

Contact Person Name _____

Contact Person Title _____

Contact Person Telephone Number _____

Contact Person FAX Number _____

Contact Person E-mail Address _____

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PRACTITIONER INFORMATION

Practitioner First Name _____

Practitioner Middle Initial _____

Practitioner Last Name _____

Practitioner Gender

☐ Female

☐ Male

Practitioner Date of Birth _____

Languages spoken (other than English) _____

Degree _____

Primary Specialty _____

Are you Board Certified?

☐ Yes

☐ No

Practitioner Type 1 National Provider Identifier (NPI) _____

Practitioner Social Security Number _____

Medicare Number _____

Medicaid Number (*required for Horizon NJ Health participation*) _____

State License Number _____

State that issued License _____

State License Expiration Date _____

I am seeking to be credentialed to join the following networks.

☐ Horizon PPO Network

☐ Horizon Managed Care Network

☐ Horizon NJ Health Networks

Please see page 16 for details on which plans/products you will be considered participating with for each of our Networks above.

If you selected Horizon NJ Health Networks above, do you wish to participate as a:

☐ Primary Care Practitioner

☐ Specialty Practitioner

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21st Century Cures Act (for Horizon NJ Health Only)

☐ If you've not already done so, providers seeking to participate with our Horizon NJ Health network must register with the State of New Jersey under the 21st Century Cures Act.

Visit our 21st Century Cures Act webpage for information about this requirement as well as details about how to register with the State of New Jersey.

Prescribing Controlled Dangerous Substances

Federal DEA Number _____

Federal DEA Expiration Date _____

☐ Prescribers who DO NOT have a Drug Enforcement Agency (DEA) Certificate must provide a completed copy of our Statement of Arrangement for Controlled Dangerous Substances: DEA Certificate form to document the arrangement with another qualified, participating physician(s) in the same network(s) to prescribe CDS on his/her behalf.

Access this form online at HorizonBlue.com/CredentialingForms.

NJ CDS Number _____

NJ CDS Expiration Date _____

☐ Prescribers who DO NOT have a New Jersey Controlled Dangerous Substance (CDS) Certificate must complete our Statement of Arrangement for Controlled Dangerous Substances: NJ CDS Certificate form to document the arrangement with another qualified, participating physician(s) in the same network(s) to prescribe CDS on his/her behalf.

Access this form online at HorizonBlue.com/CredentialingForms.

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PRACTICE INFORMATION

Practice Name _____

Practice Physical Address _____

Is the Practice Physical Address above also your residential address?

☐ Yes

☐ No

County in which your practice is located _____

Practice Tax Identification Number (TIN) _____

Practice Type 2 National Provider Identifier (NPI) _____

Practice Email _____

Administrative Practice Telephone Number _____

Telephone Number that patients call to make appointments _____

Practice Billing Address
Please provide a physical street address. Please note that PO Box information is NOT acceptable.

Billing Address _____

Telephone _____

Email Address _____

Remit Address (*for HNJH Participation Only*)
If seeking to join our Horizon NJ Health Network, please provide the address where payments/Explanations of Payments are to be directed.

Remit Address _____

Telephone _____

Email Address _____

(Continues)

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. In the absence of a CV, please complete the Medical Education fields below.

Medical Education

Name of School Issuing Professional Degree _____
(Medical, Dental, Chiropractic)

School Address _____

Degree Earned _____

Attendance Dates _____

☐ If you have attended additional schools, check this box and submit an attachment containing the information requested above for the additional schools.

Post-Graduate Education (1)

☐ Internship
☐ Fellowship
☐ Residency
☐ Teaching Appointment

Institution 1 Name _____

Address 1 Address _____

Specialty _____

Start Date *(Month/Year)* _____

End Date *(Month/Year)* _____

Post-Graduate Education (2)

☐ Internship
☐ Fellowship
☐ Residency
☐ Teaching Appointment

Institution 2 Name _____

Address 2 Address _____

Specialty _____

Start Date *(Month/Year)* _____

End Date *(Month/Year)* _____

(Continues)

Post-Graduate Education (3)

☐ Internship
☐ Fellowship
☐ Residency
☐ Teaching Appointment

Institution 3 Name _____

Address 3 Address _____

Specialty _____

Start Date *(Month/Year)* _____

End Date *(Month/Year)* _____

Other Graduate Level Education

☐ If you have completed additional training, check this box and submit an attachment containing the information requested above for the additional training.

Other Graduate Level Education for which a Degree was obtained

_____

Type of Program (*e.g., Psychology, Public Health, MBA, etc.)*

_____

Institution Name _____

Address _____

Degree Obtained _____

Date of Graduation *(Month/Year)* _____

PROFESSIONAL LIABILITY INSURANCE COVERAGE

Name of Current Malpractice Insurance Carrier _____

Address _____

Policy Number _____

Period of Coverage _____

Amount of Coverage per occurrence _____

Amount of Coverage per aggregate _____

(Continues)

SPECIAL NEEDS INFORMATION

Patient Populations
Please check the appropriate boxes to the questions below to identify the patient population categories you currently treat and to indicate if you are accepting new patients in these categories.

Do you treat children age 0 to 5?
- ☐ Yes
- ☐ No

Are you accepting new patients age 0 to 5?
- ☐ Yes
- ☐ No

Do you treat children age 6 to 12?
- ☐ Yes
- ☐ No

Are you accepting new patients age 6 to 12?
- ☐ Yes
- ☐ No

Do you treat adolescents age 13 to 17?
- ☐ Yes
- ☐ No

Are you accepting new patients age 13 to 17?
- ☐ Yes
- ☐ No

Do you treat adults age 18 to 64?
- ☐ Yes
- ☐ No

Are you accepting new patients age 18 to 64?
- ☐ Yes
- ☐ No

Do you treat adults age 65 and older?
- ☐ Yes
- ☐ No

Are you accepting new patients age 65 and older?
- ☐ Yes
- ☐ No

Special Needs Training Experience
Do you have formal training and/or experience treating adults/children with special needs including persons with physical, mental, substance abuse or developmental disabilities?
- ☐ Yes
- ☐ No

Please indicate if you have training/experience treating patients in the special needs categories below.

Do you have training/experience working with Developmentally Disabled patients?
- ☐ Yes
- ☐ No

If “Yes,” please explain below

_____

(Continues)

Do you have training/experience working with patients who are Blind?

☐ Yes

☐ No

If "Yes," please explain below

Do you have training/experience working with patients who are Deaf?

☐ Yes

☐ No

If "Yes," please explain below

Do you have training/experience working with Non-Ambulatory patients?

☐ Yes

☐ No

If "Yes," please explain below

Do you have training/experience working with patients who have HIV/Aids?

☐ Yes

☐ No

If "Yes," please explain below

Do you have training/experience working with Aged patients (i.e., 65 years and older)?

☐ Yes

☐ No

If "Yes," please explain below

(Continues)

AREAS OF EXPERTISE

Complete the appropriate section below based on your practitioner type:

- The section below should be completed by medical practitioners.
- The section on the following page should be completed by behavioral health practitioners (e.g., psychiatrists, psychologists, psychiatric nurse practitioners and LCSWs, etc.).

Areas of Expertise for MEDICAL PRACTITIONERS

Complete this section if you're NOT a behavioral health practitioner (e.g., psychiatrists, psychologists, psychiatric nurse practitioners and LCSWs, etc.).

Do you have a specific areas of interest or expertise in any medical or behavioral conditions/disorders?

☐ Yes

☐ No

If you responded "Yes" above, please explain your specific medical area(s) of interest or expertise.

Important notes about Areas of Expertise for Medical Practitioners

The information about medical area(s) of interest or expertise will be used to help us develop a list of medical practitioner Areas of Expertise (AOE) selections for future use. AOE information you provide will not be posted on our online *Doctor & Hospital Finder* at this time.

- If you note *Developmental, Individual-differences & Relationship-based Model (DIR)* as a specific area of interest or expertise, please also provide a copy of your *certification.*

  Please note that DIR services are considered eligible services only for patients enrolled in Horizon NJ Health plans/ products. DIR services are not considered eligible services for patients enrolled in Horizon BCBSNJ plans/products.

- If you note *Medication Assisted Treatment (MAT)* or *Office Based Addiction Treatment (OBAT)* as a specific area of interest or expertise, please ensure that you also complete and submit a copy of our MAT/OBAT and Navigator Attestation form.

- If you note *Telemedicine Services* as a specific area of interest or expertise, please ensure that you also complete the *Telemedicine Services Attestation* section that follows.

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Areas of Expertise for BEHAVIORAL HEALTH PRACTITIONERS ***(select up to 6)***
Complete this section if you ARE a behavioral health practitioner (e.g., psychiatrists, psychologists, psychiatric nurse practitioners, LCSWs, etc.). If you select more than 6 areas, we will only retain the first 6 alphabetically.

- ☐ Abuse, Assault and Trauma (PTSD)
- ☐ Adjustment Disorders
- ☐ Adoption
- ☐ Anger Management/Impulse Disorders
- ☐ Anxiety and Panic Disorders
- ☐ Attention Deficit Disorder (ADD/ADHD)
- ☐ Autism Spectrum Disorders (Autism/PDD/Asperger's)
- ☐ Bariatric Assessment
- ☐ Behavior Modification
- ☐ Behavioral Therapy for Autism Spectrum Disorders
- ☐ Bipolar Disorders/Manic Depressive Illness
- ☐ Brief Solution Focused
- ☐ Chemical Dependency Assessment/Treatment
- ☐ Childhood/Adolescent Behavioral Disturbances
- ☐ Christian Counseling
- ☐ Cognitive Behavioral Therapy (CBT)
- ☐ Compulsive Gambling
- ☐ Co-Occurring Disorders
- ☐ Cultural/Ethnic Issues
- ☐ Depression
- ☐ Developmental Disabilities
- ☐ Developmental, Individual-differences and Relationship-based Model (DIR)[1]
- ☐ Dialectical Behavioral Therapy (DBT)
- ☐ Disability Assessment/Treatment
- ☐ Dissociative/Identity Disorders
- ☐ Divorce/Blended Family Issues
- ☐ Eating Disorders
- ☐ Electroconvulsive Therapy (ECT)
- ☐ End of Life Issues
- ☐ Faith-Based Therapy
- ☐ Family Therapy
- ☐ Fitness For Duty Assessment
- ☐ Forensics
- ☐ Gangs/Cults
- ☐ Gay/Lesbian/Bisexual Issues
- ☐ Geriatrics
- ☐ Grief/Bereavement
- ☐ Group Therapy
- ☐ Head Trauma
- ☐ HIV/AIDS-Related Issues
- ☐ Infertility
- ☐ Medication Assisted Treatment (MAT)[2]
- ☐ Medication Management
- ☐ Men's Issues
- ☐ Military Lifestyles Issues
- ☐ Neuropsychological Testing
- ☐ Obsessive Compulsive Disorder
- ☐ Office Based Addiction Treatment (OBAT)[2]
- ☐ Pain Management
- ☐ Personality Disorders
- ☐ Play Therapy
- ☐ Postpartum Issues
- ☐ Prenatal Issues
- ☐ Psychological Testing
- ☐ Reactive Attachment Disorder
- ☐ Repetitive Transcranial Magnetic Stimulation
- ☐ Schizophrenia Disorders
- ☐ Sexual Disorders
- ☐ Sleep Disorders
- ☐ Somatic/Conversion/Factitious Disorders
- ☐ Stress Management
- ☐ Suboxone Therapy
- ☐ Telemedicine Services[3]
- ☐ Transgender Issues
- ☐ Women's Issues
- ☐ Worker’s Compensation Evaluation

(Continues)

Important Notes about Areas of Expertise for Behavioral Health Practitioners

1 If you select *Developmental, Individual-differences & Relationship-based model (DIR)* as an area of expertise, please **include a copy of your certification**. Please note that DIR services are considered eligible services only for patients enrolled in Horizon NJ Health plans/products. DIR services are not considered eligible services for patients enrolled in Horizon BCBSNJ plans/products.

2 If you select *Medication Assisted Treatment (MAT)* and/or *Office Based Addiction Treatment (OBAT)* as an area of expertise, please also complete and submit a copy of our MAT/OBAT and Navigator Attestation form.

3 If you select *Telemedicine Services* as an area of expertise, please ensure that you also complete the *Telemedicine Services Attestation* section that follows.

TELEMEDICINE SERVICES ATTESTATION

Practitioners who provide telemedicine services to Horizon BCBSNJ and/or Horizon NJ Health patients are required to comply with the guidelines of Horizon BCBSNJ's Telemedicine Services reimbursement policy and/or Horizon NJ Health's Telemedicine and Telehealth reimbursement policy.

The guidelines of these policies include, but are not limited to, the requirement that telemedicine services are conducted for the purpose of diagnosis, consultation, and/or treatment and are conducted using a HIPAA compliant and secure interactive, real-time, two-way audio-video communication technology.

☐ I attest that I comply with the guidelines of Horizon BCBSNJ's Telemedicine Services policy and/or Horizon NJ Health's Telemedicine and Telehealth reimbursement policy in the delivery of services to my patients.

Please note that our Telemedicine Services and Telemedicine and Telehealth reimbursement policies are temporarily amended to consider additional technologies/services for reimbursement during the COVID-19 pandemic. The temporary policy addenda only apply for the duration of this public health emergency.

MAT/OBAT and NAVIGATORS ATTESTATIONS

Horizon BCBSNJ and Horizon NJ Health follow guidelines established by the NJ Division of Medical Assistance and Health Services and the Division of Mental Health and Addiction Services in regard to recognizing practices as eligible to provide Medication Assisted Treatment (MAT) and Office Based Addiction Treatment (OBAT) to our members with a substance use disorder diagnosis.

Please complete the following information so that our systems may reflect your ability to provide MAT services to patients enrolled in Horizon BCBSNJ plans and your ability to provider MAT/OBAT services to patients enrolled in Horizon NJ Health plans.

Buprenorphine Waiver/Certification

Practitioner Name _____

Practitioner Specialty _____

Practitioner Type 1 NPI _____

Practitioner DEA Number _____

(Continues)

I attest that:

☐ I am a physician/physician extender who is Data 2000 waivered for prescribing buprenorphine as part of an OBAT program. *Practices **MUST** employ Navigators as part of an OBAT program.*
Please also complete the NAVIGATOR ATTESTATION *section below.*

☐ I attest that I am a physician/physician extender who is Data 2000 waivered for prescribing buprenorphine as part of Medication Assisted Treatment (MAT) program.

☐ I am not certified to prescribe buprenorphine as part of an OBAT or MAT program.
If you'd like to become certified to prescribe buprenorphine as part of an OBAT or MAT program, please contact your Provider Representative or Provider Services at **1-800-682-9091**.

Navigator Attestation
If your practice provides Office Based Addictions Treatment (OBAT) services to patients enrolled in Horizon NJ Health plans please review the following information and select the appropriate box below about your use of Navigators.

A Navigator in an Office-Based Addiction Treatment (OBAT) practice must either be:

- A Certified Medical Assistant
- A Registered Nurse (RN)
- A Social Worker
- A Licensed Practical Nurse (LPN) with two years of lived experience;
- An individual with a baccalaureate (BA) degree and two (2) years of lived experience; or
- An individual with an associate's degree and four (4) years of lived experience or
- A Certified Medical Assistant with four (4) years of lived experience.

Lived experience is defined as having knowledge of substance use disorders or mental illness gained through direct, personal experience through one's own successful recovery process as well as individuals who have gained direct experience with successful treatment of substance use disorder and/or mental illness through either a personal relationship or professional contact with individuals suffering from substance use disorder or mental illness.

Physicians, APNs and PAs **may not** serve as Navigators.

Practice Name _____

Practice Type 2 NPI _____

Practice Tax Identification Number (TIN) _____

Practice Address _____

Authorized Contact Name _____

Authorized Contact Phone _____

Authorized Contact E-Mail _____

(Continues)

As a representative authorized to speak on behalf of the practice in regard to our use of Navigators as part of an OBAT program, I attest that:

☐ **No**, the practice DOES NOT employ Navigators for OBAT.

☐ **Yes**, the practice DOES employ Navigators for OBAT who meet the criteria noted above.

If you answered "Yes" above, please provide the following information about the Navigators in your practice. Include a separate sheet as necessary.

Navigator (1) Name _____

Navigator (1) Specialty _____

Navigator (1) Type 1 NPI _____

Navigator (2) Name: _____

Navigator (2) Specialty _____

Navigator (2) Type 1 NPI _____

Navigator (3) Name _____

Navigator (3) Specialty _____

Navigator (3) Type 1 NPI _____

Navigator (4) Name _____

Navigator (4) Specialty _____

Navigator (4) Type 1 NPI _____

Navigator (5) Name _____

Navigator (5) Specialty _____

Navigator (5) Type 1 NPI _____

Navigator (6) Name _____

Navigator (6) Specialty _____

Navigator (6) Type 1 NPI _____

(Continues)

SIGNED AGREEMENT(S)

Please review, complete and sign the appropriate Agreements for the network(s) in which you are seeking participation. Information on Please see the following page for information about accessing our Agreements.

Horizon BCBSNJ Agreements

Complete and the Horizon BCBSNJ Agreements below to participate in our Horizon Managed Care Network and Horizon PPO Network.

☐ *Horizon Healthcare of New Jersey, Inc. Agreement with Participating Physicians and Other Healthcare Professionals*
Complete and sign this Agreement for participation in the Horizon Managed Care Network which allows you to treat members enrolled in our managed care plans (e.g., OMNIA, Horizon HMO, Horizon Direct Access, Horizon Medicare Advantage, Braven Health℠ plans, etc.) at an in-network level of benefits.

Some managed care plans use tiering or a subset of this network as part of their benefits. After joining this network, practices are evaluated for tier designation and subset inclusion, based on established criteria.

☐ *Horizon Blue Cross Blue Shield of New Jersey Agreement with Participating Physicians and Healthcare Professionals*
Complete and sign this Agreement for participation in the Horizon PPO Network which allows you to treat members enrolled in Horizon BCBSNJ PPO and Indemnity Plans at an in-network level of benefits.

Horizon Government Programs Provider Agreements

Complete and sign one of the following Agreement versions for participation in the Horizon NJ Health Networks that allows you to treat members enrolled in Horizon NJ Health Medicaid, NJ FamilyCare, Managed Long Term Services & Supports (MLTSS), Horizon NJ TotalCare (HMO SNP) plans.

Ensure that you access/request the appropriate Agreement version based on your specialty.

☐ *Horizon Government Programs Provider Agreements: Behavioral Health*
For Behavioral Health Practitioners, including psychiatrists, psychologists, psychiatric nurse practitioners, LCSWs, etc.

☐ *Horizon Government Programs Provider Agreements*
For Medical Practitioners/Other Healthcare Professionals.

☐ *Horizon Government Programs Provider Agreements: Nurse Practitioners and Physician Assistants*
For Nurse Practitioners and Physician Assistants (medical practitioners)

(Continues)

Horizon Government Programs Group Agreements
If your medical professional group practice wishes to participate in the Horizon NJ Health Networks under a Group Agreement, please email a request to HNJHProvider_Recruitment@HorizonBlue.com.

For behavioral health professional group practices, please email a request to BHNetworkRelations@HorizonBlue.com.

If you wish to have new practitioners credentialed and added to the group roster of your professional group practice that already participates in the Horizon NJ Health Networks under a Group Agreement, please draft a letter on your group practice's letterhead authorizing the inclusion of the practitioner(s) in question and enclose also the CAQH # for each practitioner to be added to your practice.

Please email information to EnterprisePDM@HorizonBlue.com
(email submission accepted only for the duration of the COVID-19 public health emergency)

Please mail information to the address below.

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

Accessing our Agreements
Registered NaviNet users who can access the Horizon BCBSNJ plan central page, are able to navigate to online copies of Agreements for both Horizon BCBSNJ and Horizon NJ Health Networks. Follow the steps below to navigate to this protected content online.

1. Log in to NaviNet.net and access the Horizon BCBSNJ plan central page
2. Mouse over References and Resources and click Provider Reference Materials
3. Mouse over Resources and click Manuals & User Guides
4. Click Agreements

If you have trouble accessing our Agreements online, please review the Horizon BCBSNJ Email Share information in our Credentialing Frequently Asked Questions.

If you don't have access to NaviNet, we encourage you to register. Visit HorizonBlue.com/Providers and click *Register* within the Provider Sign In window.

If you don't have access to the *Horizon BCBSNJ* plan central page, access NaviNet and submit a request to have Horizon BCBSNJ added to your profile.

As a last resort, you may email a request for the appropriate Agreement(s) to EnterprisePDM@horizonblue.com, but please note that it may take up to 10 business days to receive.

(Continues)

DISCLOSURE QUESTIONS

Please answer each question in this section. Please provide explanations of your responses as appropriate on the line below or include a separate document with the full explanation if more space is needed. If a question does not apply, please select "N/A".

Licensure

1 Has your license to practice, in your profession, ever been denied, suspended, revoked, restricted, voluntarily surrendered while under investigation or have you ever been subject to a consent order, probation or any condition or limitations by any state licensing board?

- ☐ Yes
- ☐ No
- ☐ Not Applicable

If "Yes" please explain below

_____

2 Has your federal or state narcotics license ever been suspended, limited, revoked, voluntarily suspended or not renewed, or has probation ever been invoked?

- ☐ Yes
- ☐ No
- ☐ Not Applicable

If "Yes" please explain below

_____

3 Have you ever Received a reprimand or been fined by any state licensing board?

- ☐ Yes
- ☐ No
- ☐ Not Applicable

If "Yes" please explain below

_____

Hospital Privileges and Other Affiliations

4 Have your clinical privileges at any hospital or healthcare institution ever been denied, suspended, revoked, restricted, denied renewal or subject to probationary or to other disciplinary conditions (for reasons other than non-completion of medical records when quality of care was not adversely affected) or have proceedings toward any of those ends been instituted or recommended by an hospital or health care institution, medical staff or committee, or governing board?

- ☐ Yes
- ☐ No
- ☐ Not Applicable

If "Yes" please explain below

_____

(Continues)

5 Have you voluntarily surrendered, limited your privileges, or not reapplied for privileges while under investigation?

☐ Yes
☐ No
☐ Not Applicable

If "Yes" please explain below

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6 Have you ever been terminated for cause or not renewed for cause from participation, or been subject to any disciplinary action, by a managed care organization (including HMOs, PPOs, or provider organizations such as IPAs or PHOs?

☐ Yes
☐ No
☐ Not Applicable

If "Yes" please explain below

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7 Have you ever been placed on probation, disciplined, formally reprimanded, suspended or asked to resign during an internship, fellowship, preceptorship or other clinical education program?

☐ Yes
☐ No
☐ Not Applicable

If "Yes" please explain below

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8 If you are currently in a training program, have you ever been placed on probation, disciplined, formally reprimanded, suspended or asked to resign during an internship, fellowship, residency, preceptorship, or other clinical education program?

☐ Yes
☐ No
☐ Not Applicable

If "Yes" please explain below

(Continues)

9 Have you ever, while under investigation, voluntarily withdrawn or prematurely terminated your status as a student or employee in any, internship, fellowship, residency, preceptorship, or other clinical education program?

☐ Yes

☐ No

☐ Not Applicable

If "Yes" please explain below

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10 Have any of your board certifications or eligibility ever been revoked?

☐ Yes

☐ No

☐ Not Applicable

If "Yes" please explain below

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11 Have you ever chosen not to re-certify or voluntarily suspended your board certification(s) while under investigation?

☐ Yes

☐ No

☐ Not Applicable

If "Yes" please explain below

DEA or CDS Certification/Authorization

12 Have your Federal and/or State Controlled Substances certificate(s) or authorization(s) ever been denied, suspended, and revoked, restricted, denied renewal, or voluntarily relinquished?

☐ Yes

☐ No

☐ Not Applicable

If "Yes" please explain below

(Continues)

Medicare, Medicaid and Other Governmental Program Participation

13 Have you ever been disciplined, excluded from, debarred, suspended reprimanded, sanctioned, censured, disqualified, or otherwise restricted in regard to participation in the Medicare or Medicaid program, or any other private, federal or state health program.

☐ Yes
☐ No
☐ Not Applicable

If "Yes" please explain below

Other Sanctions or Investigations

14 Are you currently or have you ever been the subject of an investigation by any hospital, licensing authority, DEA or CDS authorizing entities, education or training program, Medicare or Medicaid program, or any other private, federal or state health program?

☐ Yes
☐ No
☐ Not Applicable

If "Yes" please explain below

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15 To your knowledge, has information pertaining to you ever been reported to the National Practitioner Data Bank or Healthcare Integrity and Protection Data Bank?

☐ Yes
☐ No
☐ Not Applicable

If "Yes" please explain below

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16 Have you ever received sanctions from or been the subject of investigation by any regulatory agencies (e.g., CLIA, OSHA, etc.)

☐ Yes
☐ No
☐ Not Applicable

If "Yes" please explain below

(Continues)

17 Has a patient, employee, or co-worker ever accused you of sexual harassment or other illegal misconduct that resulted in an investigation, sanction or other formal action?

☐ Yes
☐ No
☐ Not Applicable

If "Yes" please explain below

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18 During your military career, if applicable, have you ever been investigated, sanctioned, reprimanded or cautioned by a military hospital, facility, or agency, voluntarily terminated or resigned while under investigation by a hospital/healthcare facility of any military agency?

☐ Yes
☐ No
☐ Not Applicable

If "Yes" please explain below

Professional Liability Insurance Information

19 Has your professional liability coverage ever been cancelled, restricted, declined or not renewed by the carrier based on your individual liability history?

☐ Yes
☐ No
☐ Not Applicable

If "Yes" please explain below

---

20 Have you ever been assessed a surcharge, or rated in a high risk class for specialty, by your professional liability insurance carrier, based on individual liability history?

☐ Yes
☐ No
☐ Not Applicable

If "Yes" please explain below

(Continues)

Malpractice Claims History

21 Have you ever had any malpractice actions? (Pending, settled, dropped, dismissed, arbitrated, mediated, or litigated)?

☐ Yes

☐ No

☐ Not Applicable

If you selected "Yes," please provide the information below for each case on a separate sheet. Please list each action separately.

- Date of Occurrence
- Claim/Case Status & Date Claim was filed
- Professional liability insurance carrier involved (name, address, phone & Policy number)
- Amount of award or settlement and amount paid
- Method of Resolution: Dismissed, Mediation/Arbitration, Settled (with prejudice), Settled (without Prejudice), Judgment of defendant(s), Judgment for plaintiff
- Description of allegations
- Indicate whether you were primary defendant or co-defendant
- Number of other co-defendants
- Indicate your involvement in the case (attending, consulting, etc.)
- Description of alleged injury to the patient

Criminal/Civil History

A criminal record will not necessarily be a bar to acceptance. Decisions will be based upon all relevant circumstances, including the nature of the crime.

22 Have you ever been convicted of, pled guilty to or pled nolo contendere to any felony in the last ten years or been found liable or responsible for or named as a defendant in any civil offense that is reasonably related to your qualifications, competence, functions, or duties as a medical professional?

☐ Yes

☐ No

☐ Not Applicable

If "Yes" please explain below

_____

23 Have you ever been convicted of, pled guilty to, or pled nolo contendere to any felony in the last ten years or been found liable or responsible for or named as a defendant in any civil offense that alleged fraud, an act of violence, child abuse or a sexual offense or sexual misconduct?

☐ Yes

☐ No

☐ Not Applicable

If "Yes" please explain below

_____

(Continues)

24 Have you ever been indicted in any civil or criminal suit?

☐ Yes

☐ No

☐ Not Applicable

If "Yes" please explain below

---

25 Have you ever been court-martialed for actions related to your duties as a medical professional?

☐ Yes

☐ No

☐ Not Applicable

If "Yes" please explain below

Ability to Perform Job

26 Are you able to perform the essential functions of a practitioner in your area of practice without reasonable accommodation?

☐ Yes

☐ No

If "No" please explain below

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27 Are you currently engaged in the illegal use of drugs? ("Currently" means sufficiently recent to justify a reasonable belief that the use of drugs may have an ongoing impact on one's ability to practice medicine. It is not limited to the day of, or within a matter of days or weeks before the date of an application, rather that it has occurred recently enough to indicate the individual is actively engaged in such conduct. "Illegal use of drugs" refers to drugs whose possession or distribution is unlawful under the Controlled Substances Act, 21 USC section 812.2. It does not include the use of a drug taken under supervision by a licensed health care professional, or other uses authorized by the Controlled Substances Act or other pro vision of Federal law". The term does include, however, the unlawful use of prescription controlled Substances.)

☐ Yes

☐ No

☐ Not Applicable

If "Yes" please explain below

(Continues)

28 Do you use any chemical substances that would in any way impair or limit your ability to practice medicine and perform the functions of your job with reasonable skill and safety?

☐ Yes
☐ No
☐ Not Applicable

If "Yes" please explain below

_____

29 Do you have any reason to believe that you would pose a risk to the safety or well-being of your patients?

☐ Yes
☐ No
☐ Not Applicable

If "Yes" please explain below

_____

30 Do you have Professional Liability (Malpractice) Insurance coverage in force?

☐ Yes
☐ No

If "No" please explain below

_____

ATTESTATION

☐ I attest that all answers provided and the information submitted by me in this application form are true and correct to the best of my knowledge and belief. I understand that any of this information which is subsequently found to be false, misleading or incomplete, could result in denial of this application or termination of my participation in the Network(s).

Practitioner Name _____

Practitioner Signature _____

Date _____