RESET

Ancillary Provider Disclosure Questions

Participating ancillary providers must complete and submit this form to accompany requests to add a new location or for the relocation of an existing location. Incomplete disclosures may result in delays in processing your requests.

Mail this completed form, along with your request and other supporting documentation, to:

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

You may also email this completed form, along with your request and other supporting documentation, to EnterprisePDM@horizonblue.com.

Provider Name _____

Street Address _____

City State ZIP _____

Telephone Number _____

TIN _____

NPI _____

NJ Medicaid Provider Number _____

Disclosure Questions
Please select the appropriate response to each question below. For all questions to which you respond "Yes," please provide an explanation of each case (including the date[s] of each incident and the final outcome).

1 Does your organization have any pending, settled, dropped or dismissed liability cases?

- ☐ Yes
- ☐ No

2 Has your organization (or any owner controlling 10 percent or more of your organization) ever been subjected to or is currently undergoing any of the following:

a Government disciplinary action such as, but not limited to, revocation of license or Medicare/Medicaid provider status?

- ☐ Yes
- ☐ No

b Medicare and/or Medicaid sanction within the last five years?

- ☐ Yes
- ☐ No

c Criminal or ethical investigation or conviction?

- ☐ Yes
- ☐ No

(Continues)

d Bankruptcy, insolvency or assignment for the benefit or creditor proceedings?

☐ Yes

☐ No

e Received any member complaints in the past 12 months?

☐ Yes

☐ No

Affirmation of Information

All information submitted by me on behalf of _____ an ancillary provider (the “provider”) is true and correct to the best of my knowledge and belief. I understand that as an authorized representative of the provider, I have the right to review the information submitted in support of the provider’s application. I understand that if any of this information is subsequently found to be false, misleading or incomplete, it could result in denial of the provider’s application or termination of participation in the Horizon Blue Cross Blue Shield of New Jersey provider network, or any of its subsidiary or affiliate provider networks (hereafter collectively referred to as "Horizon BCBSNJ").

I understand and agree that I have the responsibility for producing adequate and accurate information for proper evaluation of the qualifications of the provider and for resolving any doubts about such qualifications. I also agree to provide information on an ongoing basis as requested and in accordance with any specific future request that is relevant to Horizon BCBSNJ's evaluation of the provider’s application, credentials or qualifications, and that this statement in its entirety shall also apply then.

Name of Authorized Representative _____

Title _____

Signature _____

Date _____