

It's good to be Blue.

How-to Guide

eCredentialing

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"How To" Guide for Online Provider Credentialing December 2012

Online Provider Credentialing is now available through *my*Blue Provider. The new online Provider Credentialing Tool will allow users to apply for network status for new providers, re-credential existing network providers, upload and electronically submit all supporting documents, verify status of your network application and receive all provider credentialing correspondence electronically. The following information will guide you through the screens to assist you in using the online Provider Credentialing Tool.

myBlue Provider Home Page – Initial Application Process

To submit a network enrollment application for a new provider, click on the 'Provider Enrollment Applications' link under the Transactions section located on the *my*Blue Provider Home Page. If the 'Provider Enrollment Applications' link is not listed, please contact your Super User to have the appropriate access granted to your current *my*Blue Provider profile. If additional assistance is needed to establish the appropriate *my*Blue Provider access, please contact our EDI Services Department at 1-800-826-4068.



Provider Credentialing Home Screen – New Provider

The initial step of the provider enrollment process is selecting the provider type and which network in which you are requesting membership. Providers can apply for both the Blue Cross & Blue Shield of Mississippi (BCBSMS) and the State Employee Health Plan, a.k.a. Advanced Health Systems (AHS), Networks through this provider enrollment process.

Once you have selected the provider type and network, select the federal tax identification number the provider will be affiliated with and enter the provider's unique NPI number. If the federal tax identification number affiliated with this provider is not listed, please contact your Super User to have this tax identification number added to your current *my*Blue Provider profile. If additional assistance is needed to establish the appropriate tax identification numbers, please contact our EDI Services Department at 1-800-826-4068.

After the tax identification number and performing NPI number has been provided, click "Continue" to start a new application. Once a new application has been started, it must be completed and submitted within three business days.

rovider Credentialing	
Start a Provider App	plication
Start a new Application Packag please contact us via e-mail at	e by providing the information and click Continue. If you do not see your provider type listed, providerdatabase@bcbsms.com.
Select a Provider Type	Select Provider Application 👻
Select a Network	Select Network Vhat's this
Federal Tax ID	Select Tax ID 🔹
Performing NPI ID	
Continue	e Cancel

Note: If the provider type selected is not eligible for enrollment in the network selected, an error message will be received. If no network is offered for the selected provider type, you are required however to complete an application package to validate your NPI number. This process will allow you to file claims for services provided to Blue Cross and Blue Shield and State Health Plan members.

Application Criteria Screen – New Provider

During the application process, the supporting information needed to determine if the provider meets the minimum criteria for acceptance in the respective network(s) will be required to be entered via the online application or uploaded as a document. Providers that do not have the ability to upload documents will be able to fax the information needed. The Application Criteria screen provides a summary of the applicable network criteria, as well as a list of the supporting information that will be needed to complete the credentialing process.

Provider Credentialing - Important Information regarding your Physician Application

Thank you for your interest in becoming a Blue Cross & Blue Shield of Mississippi (BCBSMS) and/or Advanced Health Systems (AHS) provider. Our online application process requires that you enter all required provider information and upload or fax related documents. The process is detailed. However, you will be "walked through" each step to ensure that you include all necessary information. Once you complete the application, you will submit it and all required documentation for our review. **Please note that we will not be able to review or process your application unless all required information and documentation is included.** Once the application is started, you must complete and submit it within three (3) business days, along with any required supporting documentation. Therefore, if for any reason your application is not completed and submitted within this time, it will be rejected. However, you may re-apply at a later date.

If you are applying for network participation, approval is contingent upon you meeting the requirements set forth in this online application, as well as the execution of all applicable agreements. This website will be the primary method of communication regarding your application. You should check the *my*Notifications section for any questions or responses to your application. Important: If you are submitting an <u>initial</u> application, please do not file claims until you have been notified to do so.

Please see below for a summary of required information and criteria that you will need to meet and submit to be considered for network participation.

Physician Criteria

- Have a current, unrestricted DEA license. NOTE: Providers who do not have Schedules 2, 2N, 3, 3N, 4 and 5 must provide a written explanation for the omission. These providers will be considered on an individual basis and may be asked to obtain all Schedules;
- Be currently or previously board certified or currently board eligible through the American Board of Medical Specialties (ABMS) or the American Osteopathic Association (AOA) for MDs and DOs or the American Board of Oral and Maxillofacial Surgery for DMDs and DDSs. (Providers who are certified through foreign specialty boards will be considered on an individual basis relative to their equivalency of training as determined by Blue Cross & Blue Shield of Mississippi or AHS State Network and its Credentials Verification committee.) NOTE: Providers are considered board eligible for initial certification for five (5) years after residency has been completed or for the time-period set by the certifying board, whichever is less. Providers will not be considered board eligible for purposes of network participation after these time periods;
- Have active hospital privileges at a hospital or sufficient referral mechanism for patient admission. NOTE: Individual consideration is given based on practice and location;
- Have valid Medicare and Medicaid provider numbers;
- Submit a completed application and network agreement(s);
- Submit claims electronically;
- Enroll in myAccessBlue for on-line access to benefits, eligibility, claims status and vouchers;
- Enroll in ACH for electronic payment;
- Have a current, unrestricted license to practice/operate in Mississippi and/or in other states where licensed;
- Maintain a minimum of \$500,000 per occurrence/\$1,000,000 aggregate professional liability coverage with an approved carrier. NOTE: Individual consideration is given to providers with FTCA (Federal Tort Claims Act) coverage or MTCA (MS Tort Claims Act) coverage for employees of state governmental entities in accordance with Miss. Code Section 11-46-15. Documentation supporting the provider's coverage through these means must be provided;
- Provide Malpractice Claims History Report(s) produced by your professional liability insurance carrier(s) reflecting the past 5 years or a NPDB report. Note: Providers who have had no malpractice claims must also submit this information. If the applicant completed their education during the past 5 years, a claims history report must be submitted reflecting all dates after completion. Please request from your current carrier as well as past carriers with whom you held a policy over the past 5 years;
- Be non-listed in OIG's Cumulative Sanctions Report (Medicare/Medicaid);
- Provide a completed W-9 form;
- Provide satisfactory responses to general questions regarding history of restrictions on licenses, privileges, convictions, etc.; history of malpractice claims; and health conditions affecting practice ability.

Provider Remote System Access Agreement You will complete this online. Necessary information includes:

 Name, job title, telephone number and email of the provider staff member who will be responsible for the organization's access to its online services with Blue Cross & Blue Shield of Mississippi and/or Advanced Health Systems, Inc.

Authorization Agreement for Automatic Deposits You will complete this online, print a copy for signature and upload or fax your signed document, voided check, and letter from the bank.

Depository (Bank) Name

Provider Application Home Screen – New Provider

The Provider Application Home screen contains links to the enrollment application and any applicable agreements that must be completed. The agreements listed will be dependent on the provider and network types selected. This screen also provides links to upload any necessary supporting documents for the application. Based on the information entered on the initial screen, the NPI number and tax identification number will be automatically populated and listed on this screen for reference. The provider name will also be listed once the application has been started.

To start the application process, simply click on the application link.

Provider Credentialing - Physician Click Here for Network Criteria NAME: Doe, Jane NPI ID: 1234567890 Tax ID: 987654321 Complete these online documents Documents Last Activity Date Status Mississippi Network Physician Application N/A Not Yet Started 2. BCBSMS Key Physician Agreement N/A Not Yet Started 3. AHS State Network Healthcare Professional Agreement N/A Not Yet Started 4. Electronic Submission of Claims (ESC) Agreement N/A Not Yet Started Provider Remote System Access Agreement N/A Not Yet Started 5 6. Authorization Agreement for Automatic Deposits N/A Not Yet Started 2 Supporting Documentation Some documents related to your practice are necessary. Others may be necessary based on the specifics of your practice. Please Upload or Fax all applicable supporting documentation for your application. Documents to Upload Last Activity Date Certificate of Liability Insurance N/A Upload documents Claim History or National Practitioner Data Bank Report N/A Upload documents N/A State License Upload documents DEA Certificate N/A Upload documents Hospital Privileges N/A Upload documents CLIA Certificate/Waiver N/A Upload documents Curriculum Vitae N/A Upload documents Medicare/Medicaid Provider Number(s) N/A Upload documents Authorization Agreement for Automatic Deposits N/A Upload documents Electronic Submission of Claims (ESC) Agreement N/A Upload documents W-9 Form N/A Upload documents Click here to download the required W-9 form Upon completion, sign and upload or fax. Click here to submit other additional documents If you are unable to upload documents, please click here for fax cover sheet. Submit Application Packet for Credentialing Please click the button below to submit the application packet. After you submit the application packet you will not be allowed to make any changes to the application other than viewing the submitted information.

Note: To review the minimum criteria for acceptance, click the "Network Criteria" link in the top righthand corner of the page.

Submit Application

Back to View Applications

Provider Application – New Provider

The Provider Application is a multiple page electronic document that allows the user to enter the required provider information online. The user must complete the entire Provider Application before the application packet can be submitted for review. Required fields will be indicated by an asterisk.

Once all the required information is provided on a page, the user must click the "Save & Continue" button at the bottom of the page to save the information and proceed to the next page of the application.

	ge 2 of 22	Pa	ge 3 of 22	Page 4 of 22		Page 5 of 22	Page 6 of 2
A - I. IDENTIFYING IN *First Name:	NFORMATION	Middle Na	ame:	*Last	Name:		Suffix:
John				Doe			MD
*Degree/Certification:							
MD -							
Is there any other nam have been known (i.e	me under which Maiden Name)?	you	NPI:	Gender:		*Date of Birth:	
			1234567890	🔍 Male 🔘 Female		11/15/1989	
				(Used for consume	r es estul		
Birth Place Country:				mormation purpos	es only)		
UNITED STATES				•			
Birth Place City:			Birth Place Sta	ite:			
Jackson			MISSISSIPP	•			
Social Security Numbe	er: Race/E	thnicity ((Optional):	U.S. Citizen:			
123456789				🖲 Yes 🔘 No			
Home Address Line 1:				Home Address Line	2:		
1234 Home St							
City:			State:		Zip Code:		
Jackson			MISSISSIPP	•	39215		
Email Address:							
email@email.com							
Home Phone:	Home F	ax:		Mobile Phone:	_		
601-555-5555	601-55	5-5555		601-555-5555			
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General Practice							
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General Practice Subspeciality: Select Subspecialty Subspeciality:		•					

Note: At any time during the application process, you may cancel the application and return at a later time to complete the application. However, you must "Save & Continue" to the next screen to prevent losing information that has already been entered. By clicking the "Save & Continue" button, you are saving your information. If any error messages exist, these messages must be resolved before the information can be saved. If you do not click "Save & Continue" before cancelling the application, any information entered on that page will be lost. **Reminder: Once a new application has been started, it must be completed and submitted within three business days.**

Provider Application – New Provider (Continued)

There are several pages of the application that require information to be "added" prior to continuing to the next page. These are pages where more than one set of information may apply. For example, a provider may practice at multiple locations or have multiple degrees from different universities. These pages will include an "Add" button in the corresponding section of the application. Once the initial set of information is "added," the user will be able to "add" additional information or click "Save & Continue" to save entered info and proceed to the next page of the application.

During the application process, providers will be asked to provide practice information. Only the practice locations associated with the available tax identification numbers should be entered on this screen. If the provider practices at additional locations associated with tax identification numbers that are not listed, the provider will need to complete an 'Additional Location Application' once the credentialing process has been completed. The 'Additional Location Application' is available under the Form Download section of *my*Blue Provider.

Dep: Affiliated with Tax ID: Medical Gro	artment Name (if ho	ospital-based): ederal Tax Id:	*Office Group	
e Affiliated with Tax ID: E Medical Gro	*Fe	ederal Tax Id:	*Office Group	
e Affiliated with Tax ID: E Medical Gro	*Fe	ederal Tax Id:	*Office Group	
E Medical Gro				NPI:
	0.	elect Tax ID 🔻	1234567890	
*State:	*Zip Coo	de: *County	:	
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Physical Address				
Addr	ress Line 2:			
	Physical Address	vur primary office address? Address Line 2: *State: *Zip Con MISSISSIPPI ◆ 39215 Physical Address	Physical Address Address Line 2: *State: Physical Address Address Line 2: *Zip Code: *Zip Code: *Zip Code: *County J39215 HINDS	Physical Address Address Line 2: *State: Physical Address Address Line 2: *Zip Code: *Zip Code: *County: HINDS Address Line 2: *Zip Code: *County: HINDS

Note: Only the tax identification numbers associated with the user's *my*Blue Provider profile will be listed in the drop-down menu.

Provider Application – New Provider (Continued)

Once the practice location information has been entered, click the "Add Practice Location" button to save the practice location information. To add an additional location, enter the additional location information and click the "Add Practice Location" button to save the additional practice location information. Repeat this process for any additional locations.

Note: Once the information has been "added" the user will have the ability to edit or delete the information if needed.

*Address Line 1			Add	ress Line 2:		
1234 Main St						
*City:			*State:	*Zip Code:	*County:	
Jackson			MISSISSIPPI	▼ 39215	HINDS -	
lailing Address						
anng Haarooo		Same as	Physical Address			
*Address Line 1	:		Add	ress Line 2:		
1234 Main St			***	*=` -= -	**	
*City:			*State:	*Zip Code:	*County:	
Jackson			MISSISSIPPI	▼ 39215	HINDS •	
*Appointment Phon	e:	Extension:	Office Fax:	-		
601-555-5555		123	601-555-5555			
*Do you have office	e TTD Phon	e? 🔘 Yes (No			
Office Manager (Add						
Office Manager/Adr *First N	ninistrator: lame:		Middle Name:	*Last Name:		
Sally			Sue	Smith		
*Pho	*Phone: Extens		ion: Fax:	Back Offic	Back Office/Business Office Phone:	
601-	601-555-5555 456		601-555-5555	601-555-5	601-555-5555	
*Is your office hand	dicap acces	sible? 🔘 '	Yes 🔘 No 🏾 *Do	you have 24-hour cov	erage? 💿 Yes 🔘 No	
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After all application practice locations have been "added," click "Save & Continue" to save entered info and proceed to the next page of the application.

Provider Application – New Provider (Continued)

If for any reason the application is not able to be completed in its entirety after the application was initially started, the user will have **three business days** to complete and submit the application. As a reminder, the date of required completion will be displayed once the application has been started. An application that has not been completed will show as "In Progress" on the Provider Credentialing Home screen. The date of the last activity on the application will also be listed.



Once the application has been completed, it will show as "Completed." The user will also have the option of viewing the information entered in a PDF format for review prior to submission. Until the application is submitted, the user will also have the ability to edit the application as needed. Any changes to the application will require the provider to reconfirm any agreements or affirmations.

Complete these online documents by 07/29/2012		
Documents	Last Activity Date	Status
 Mississippi Network Physician Application BCBSMS Key Physician Agreement AHS State Network Healthcare Professional Agreement Electronic Submission of Claims (ESC) Agreement Provider Remote System Access Agreement Authorization Agreement for Automatic Deposits 	07/26 N/A N/A N/A N/A N/A	Completed <u>View Information</u> Not Yet Started Not Yet Started Not Yet Started Not Yet Started Not Yet Started

Provider Network Agreements – New Provider

Based on the network type selected, the Blue Cross & Blue Shield of Mississippi (BCBSMS), Advanced Health System (AHS), or both agreements will be listed as documents that require completion. If the user selected "No Networks" during the initial request, no agreements will be listed.

Provider Credentialing - Physician

Click Here for Network Criteria

NAME: Doe, John	NPI ID: 1376754002	Tax ID: 753198932	
Complete these online documents by 07/2	29/2012 Last Activity Date	Status	
 Mississippi Network Physician Application BCBSMS Key Physician Agreement AHS State Network Healthcare Professional Agreement Electronic Submission of Claims (ESC) Agreement Provider Remote System Access Agreement Authorization Agreement for Automatic Deposits 	07/26/2012 N/A N/A N/A N/A N/A	Completed <u>View Information</u> Not Yet Started Not Yet Started Not Yet Started Not Yet Started Not Yet Started	

2 Supporting Documentation

Some documents related to your practice are necessary. Others may be necessary based on the specifics of your practice. Please Upload or Fax all applicable supporting documentation for your application.

Documents to Upload	Last Activity Date	
Certificate of Liability Insurance	N/A	Upload documents
Claim History or National Practitioner Data Bank Report	N/A	Upload documents
State License	N/A	Upload documents
DEA Certificate	N/A	Upload documents
Hospital Privileges	N/A	Upload documents
CLIA Certificate/Waiver	N/A	Upload documents
Curriculum Vitae	N/A	Upload documents
Medicare/Medicaid Provider Number(s)	N/A	Upload documents
Authorization Agreement for Automatic Deposits	N/A	Upload documents
Electronic Submission of Claims (ESC) Agreement	N/A	Upload documents
W-9 Form	N/A	Upload documents

Click here to download the required W-9 form Upon completion, sign and upload or fax.

Click here to submit other additional documents.

If you are unable to upload documents, please click here for fax cover sheet.

3 Submit Application Packet for Credentialing

Please click the button below to submit the application packet. After you submit the application packet you will not be allowed to make any changes to the application other than viewing the submitted information.



Provider Network Agreements – New Provider (Continued)

The Provider Network Agreements are a single page electronic document that allows the user to read the actual BCBSMS and/or AHS Network agreements. Once the user has read the network agreement and entered the needed provider information, the user must accept the agreement to be considered for acceptance in the corresponding network.

The BCBSMS Network Agreement allows the provider to indicate if they want to be included in the directory of Participating Network Providers.

	SS & BLOE SHIELD	OF MISSISSIPPI KE	Y PHYSICIAN AG	REEMENT
Plea	ase read the agreeme	nt details below.		
	DEFINITIONS a. "Key Physician" me PLAN wherein the Key care services to PLAN b. "Subscriber(s)" me covered under a Subs benefits as defined in c. "Subscriber Contra administered by PLAN Shield Plan with which receive health care be Contract/Certificate ex surgical/medical scheo d. "Professional Allow analysis of physician of covered under the ter AGREEMENTS OF PH The PHYSICIAN hereby a a. Provide medical se accordance with the s	eans a PHYSICIAN who has e Physician, as a participating Subscribers. ans employees or individuals criber Contract/Certificate wl and pursuant to a Subscribe ct/Certificate" means any cor , its subsidiaries and affiliate 1 PLAN has a participating ag mefits as defined in and purs kcept for the PLAN's Medicare dule and indemnity contracts. vance" means the amount es charges, as the maximum am ms of the Subscriber's Contr tySICIAN Igrees to: rivices to PLAN Subscribers in ame standards as services a	ntered into this Agreemer provider, agrees to rende and their enrolled deper no are entitled to receive r Contract/Certificate. htract/certificate issued or s, or another Blue Cross a reement, entitling Subscri uant to a Subscriber complementary contracts itablished by the PLAN, ba ount allowed for physiciar act/Certificate.	at with the er health E idents health care and Blue bers to s, ised on an a services
	b. Accent the PLAN's	ame standards as services a navment plus the Subscriber	re provided to all other pa 's deductible and	v
*Phy:	sician Name: MD, John		nic Name: ME Modicol Clinic	
Tax 1 9876	identification Number: 154321 jal Security Number:	*Specialty:		
9876	54321	General Practic	e -	
Office Addre	55			
*	Address Line 1:	Add	ress Line 2:	
	1234 Main St			
-	City:	*State:	"Zip Code:	*Phone #:
-	Jackson	MISSISSIPPI	▼ 39215	601-555-5555
Billing Addre	SS			
	Address Line 1:	Add	ress Line 2:	
	1234 Main St			
-	C.I.V.	Totate:	"Zip Code:	-moné #:
•	lookaan	Mieciecippi	- 20215	CO1.CCC.CCCC
J	Jackson	MISSISSIPPI		601-555-5555
*Prov	Jackson vider Electronic Signature:	MISSISSIPPI	• 39215 I:	601-555-5555 "Date Signed:

Once the Provider Network Agreement has been completed and the provider's electronic signature has been provided, click "Save" to continue.

Additional Provider Agreements – New Provider

In addition to the Provider Application and Network Agreements, inclusion in the BCBSMS and/or AHS Networks requires providers to file claims electronically, receive payments electronically and have access to *my*Blue Provider. These agreements must also be completed prior to submitting the provider enrollment application for review. If your clinic already files claims electronically, receives payments electronically and has access to *my*Blue Provider, these agreements will not be required.

Provider Credentialing - Physician

Click Here for Network Criteria

NAME: Doe, John	NPI ID: 1376754002	Т	ax ID: 753198932
1 Complete these online documents by 07	//29/2012		
Documents		Last Activity Date	Status
 Mississippi Network Physician Application BCBSMS Key Physician Agreement AHS State Network Healthcare Professional Agreement Electronic Submission of Claims (ESC) Agreement Provider Remote System Access Agreement Authorization Agreement for Automatic Deposits 		07/26/2012 07/26/2012 07/26/2012 N/A N/A N/A	Completed <u>View Information</u> Completed <u>View Information</u> Completed <u>View Information</u> Not Yet Started Not Yet Started Not Yet Started
2 Supporting Documentation			

Some documents related to your practice are necessary. Others may be necessary based on the specifics of your practice. Please Upload or Fax all applicable supporting documentation for your application.

Documents to Upload	Last Activity Date	
Certificate of Liability Insurance	N/A	Upload documents
Claim History or National Practitioner Data Bank Report	N/A	Upload documents
State License	N/A	Upload documents
DEA Certificate	N/A	Upload documents
Hospital Privileges	N/A	Upload documents
CLIA Certificate/Waiver	N/A	Upload documents
Curriculum Vitae	N/A	Upload documents
Medicare/Medicaid Provider Number(s)	N/A	Upload documents
Authorization Agreement for Automatic Deposits	N/A	Upload documents
Electronic Submission of Claims (ESC) Agreement	N/A	Upload documents
W-9 Form	N/A	Upload documents
Click here to download the required W-9 form Upon completion, sign and upload or fax.		

Click here to submit other additional documents.

If you are unable to upload documents, please click here for fax cover sheet.

3 Submit Application Packet for Credentialing

Please click the button below to submit the application packet. After you submit the application packet you will not be allowed to make any changes to the application other than viewing the submitted information.

Back to View Applications

Submit Application

Electronic Submission of Claims Agreement

The Electronic Submission of Claims (ESC) Agreement is required in order to submit claims electronically for processing. Similar to the Network Agreements, this electronic document allows the user to read the actual ESC agreement. Once the user has read the ESC agreement and entered the needed provider information, the user must accept the agreement to be set up to file claims electronically.

If the Provider uses an authorized billing agency or clearinghouse to submit claims on the Provider's behalf, the billing and clearinghouse information will also be required.

Note: If the provider uses a billing agency or clearinghouse to file their claims, the ESC agreement will need to be physically signed by the billing or clearinghouse and submitted either by upload or fax to BCBSMS for review with all applicable signatures.

ment For Electronic Clair	ns Submission	
Please read the agreeme	ent details below.	
I. TERMS The Provider certifies A. All services render supervision in its facil B. Authorization for p has been fully execut applicable, appropriat certification/recertifica will be maintained by C. Properly filed sour that the Plan, or its d submitted. Any incorre- will be adjusted accor- amended, regulations Plan policy guideliness D. In the event the P Clearinghouse, the Pr successor Billing Ager Also, in the event of a immediately. E. In the event a Billi	and specifically agrees that: red were performed by the Provider or unity. Deayment to the Provider and for release ed by the patient. The required patient se is signatures on behalf of patients, required ation, and PSRO certifications, where app the Provider. ree documents will be maintained by the esignees, have the right to audit and con- ect payments which are discovered as a rding to applicable provisions of the Socia s, guidelines and provisions contained in Provider discontinues its relationship with rovider will notify the Plan immediately and they's or Clearinghouse's name, address a any such discontinuance, this Agreement	nder the Provider's of medical information signature, or where ired physician blicable, are on file and Provider who agrees nfirm any information result of such an audit al Security Act as the Plan's contracts, and in the Billing Agency or ind will supply the and contact personnel. will terminate
*Agreement Date: 11/26/2012	Tax Identificatio 987654321	n:
*Provider Name: John Doe, MD	Billing Agency Name: ACME Billing	Clearinghouse Name: ACME Clearinghouse
*Provider Electronic Signature: John M Doe, MD PROVIDER hereby executes this Elect Claims Agreement" and through PROV	*NPI: 1234567890 ronic Claims Agreement by clicking the box r /IDER's electronic signature and NPI number	*Date Signed: 11/26/2012 marked "I have read & accept the Electronic rentered above.
I have read & accept the Elect	ronic Claims Agreement	
	Save Cancel	

Electronic Submission of Claims Agreement (Continued)

In some cases, an electronic claims submission agreement may already be on file. Based on the tax identification number, if an agreement is already on file, a message will be received and an agreement will not be required.

Our records indicate you already have an Electronic Submission of Claims agreement on file. No further action is required. Click Done to complete the process.	Agreement For Electronic Claims Submission
Done	Our records indicate you already have an Electronic Submission of Claims agreement on file. No further action is required. Click Done to complete the process.

Remote System Access Agreement

The Remote System Access agreement is required in order to set a provider up with access to *my*Blue Provider. Once a provider has been set up with *my*Blue Provider access, the provider will have the ability to verify their patients' eligibility, benefits and claim status. The provider will also have access to a variety of electronic tools to assist the provider with providing the best quality of care to their Blue Cross and Blue Shield patients.

Provider Remote System Acc	ess Agreement			
Please read the agree	ment details below			
1. ACCESS TO CO Subject to the pro- access to its provid their enrolled depe but are not limited vouchers and med means any Contra affiliates, entitling benefits as defined system shall be lim 2. CONFIDENTIAL a. CLIENT underst data, or document proprietary (hereir Confidential Inform programs, applicat literature and mate b. CLIENT, as well the confidentiality shall not at any tin download license. *Name: John Doe. MD	MPUTER SYSTEM ovisions of this paragraph der web-site, myAccessBl andents covered under a to, member eligibility and ical policy. For purposes of ct/Certificate issued or ac subscribers and their cov d in the Contract/Certifica hited to Contracts/Certifica AND PROPRIETARY INFOR tands and acknowledges ation accessed by CLIENT aafter referred to as "Con nation includes, but is not tions, database files, as w erial on its computer syst I as its officers, directors, of all Confidential Informa ne, in manner or form, dir cell reveal diwulge trac	I, BCBSMS shall allow CLIE ue, to conduct activities for Contract/Certificate. Such d benefits inquiry, claim st of this Agreement, Contract dministered by BCBSMS, it ered dependents to recei- te. CLIENT's access to BC ates designated by BCBSI MATION that any and all of BCBSM T is considered confidentia fidential Information"). BC ilimited to, information fro- vell as any other data, doo em. and employees, shall at a ation and/or the proprieta ectly or indirectly, copy, di sefer_publish or communic *Client Name: ACME Medical Clinic	ENT controlled or subscribers and activities include, atus inquiry, view ct/Certificate s subsidiaries and ve health care BSMS' computer MS. 15' information, al and/or 2BSMS' mmyAccessBlue cumentation, all times preserve ry system and sclose, duplicate, ate_in whole or in	
*Agreement Date:		Tax Identification:		
11/26/2012		987654321		
Addross		307034321		
*Address Line 1:		Address Line 2:		
1234 Main St				
*Citv:	*State:		*Zip Code:	
Jackson	MISSISSI	PPI 🔹	39215	
*Provider's Electronic Signature:	*NPI: *Title:	*:	Date:	
John M Doe MD	1234567890 Chief Exe	cutive Officer	1/26/2012	
PROVIDER hereby executes this Pr Provider Remote System Access A I have read & accept the Pr I do not accept	rovider Remote System Acc greement" and through PRC rovider Remote System J	ess Agreement by clicking th DVIDER's electronic signature Access Agreement	ne box marked "I have a and NPI number enter	read & accept the red above.
	Save	Cancel		

Remote System Access Agreement (Continued)

In some cases, a Remote System Access agreement may already be on file. Based on the tax identification number, if an agreement is already on file, a message will be received and an agreement will not be required.

ovider Remote System Access Agreement
Our records indicate you already have a Remote System Access agreement on file. No further action is required. Click Done to complete the process.

Authorization Agreement for Automatic Deposits

Unlike the Electronic Submission of Claims and Remote System Access agreements, the user will need to verify if an Authorization Agreement for Automatic Deposits (ACH) is on file prior to being able to complete the form. To verify if an ACH agreement is already on file, the appropriate Voucher ID must be selected. The Voucher ID is the number associated with the Provider Remittance Statement. In most cases, this number will be related to the tax identification number.

ACH Setup		
To verify if an associated wi The on If n Ple	Authorization Agreement for Automatic Deposit (ACH) is already on file, please select the Voucher ID h your tax identification number and click "Continue". • Voucher ID is listed on the your provider remittance statement near the top of each page and is based your tax identification number. nultiple locations exist, an alpha suffix is appended to the Voucher ID for each location. If applicable, ase ensure to select the Voucher ID with the appropriate alpha suffix.	
*Voucher Id:	Select Voucher ID Continue Cancel	

Once the Voucher ID is selected, click "Continue" to verify if an ACH agreement is already on file. If an agreement is already on file, a message will be received that ACH information is already on file. If this message is received, an ACH agreement will not be required. Click "Done" to return to the Provider Application Home screen.

ACH Setup							
*Voucher Id: ACH Information	987654321 n on file - Click "Up	▼ odate ACH" butto	on to update informa	tion or "Done'	" to complete s	etup.	
		Continue	Update ACH	Done	Cancel		

Note: If ACH information is already on file, the user can update the ACH information if needed. An updated ACH form, however, will be required to be submitted along with supporting banking documentation.

If an agreement is not already on file, you will be taken directly to the electronic ACH agreement for completion.

Authorization Agreement for Automatic Deposits (Continued)

The Authorization Agreement for Automatic Deposits (ACH) is required in order to be paid electronically. The ACH agreement can be filled out electronically but is required to be physically signed and electronically submitted with a voided check and a letter of verification from the bank.

*Type of account:	Checking	g 🔘 Savings			
*Company Name:					
ACME Medical Clinic					
*Depository (Bank) Na	me:	*	Branch:		
State Bank		ſ	Downtown		
*City:		*State:	*Zip:		
Jackson		MISSISSIPPI			
*Transit ABA #:	*Account #:	Tax Identif	ication #:		
123456789	123456789	98765432			
*Confirm Transit ABA #:	*Confirm Account #:				
123456789	123456789				
reasonable opportunity ity Contact Informa *Name: John Smith	/ to act on it. tion *Title: CEO		*Email Address: email@email.co	m	
reasonable opportunity rity Contact Informa *Name: John Smith Note: Person signin an authorized acco below.	r to act on it. tion *Title: CEO ng must be the Chief Ex unt representative for t	kecutive Officer, Chief the checking account	*Email Address: email@email.co Financial Officer, Manag isted above. Also, a witr	m ing Partner or Owner less signature must be	and must be included
reasonable opportunity rity Contact Informa *Name: John Smith Note: Person signir an authorized acco below. ate Contact Informa	v to act on it. tion *Title: CEO ng must be the Chief Ex unt representative for t	kecutive Officer, Chief the checking account	*Email Address: email@email.co Financial Officer, Manag isted above. Also, a witr	m ing Partner or Owner less signature must be	and must be ; included
reasonable opportunity rity Contact Informa *Name: John Smith Note: Person signir an authorized acco below. ate Contact Informat *Name:	v to act on it. tion *Title: CEO ng must be the Chief Ex- unt representative for t tion *Title	kecutive Officer, Chief the checking account e:	*Email Address: email@email.co Financial Officer, Manag isted above. Also, a witr *Phone Numb	m ing Partner or Owner less signature must be per:	and must be
reasonable opportunity rity Contact Informa *Name: John Smith Note: Person signin an authorized acco below. ate Contact Informa *Name: Sally Smith	v to act on it. tion *Title: CEO ng must be the Chief Ex- unt representative for t tion *Titl Offic	kecutive Officer, Chief the checking account e: ce Manager	*Email Address: email@email.co Financial Officer, Manag isted above. Also, a with *Phone Numl 601-555-555	m ing Partner or Owner less signature must be per: 5	and must be included
reasonable opportunity rity Contact Informa *Name: John Smith Note: Person signir an authorized acco below. ate Contact Informat *Name: Sally Smith *Email Address:	v to act on it. tion *Title: CEO ng must be the Chief Ex- unt representative for t tion *Title Office	kecutive Officer, Chief the checking account e: ce Manager	*Email Address: email@email.co Financial Officer, Manag isted above. Also, a witr *Phone Numb 601-555-555	m ing Partner or Owner less signature must be ber: 5	and must be included
reasonable opportunity ity Contact Informa *Name: John Smith Note: Person signin an authorized acco below. ate Contact Informat *Name: Sally Smith *Email Address: email@email.com	v to act on it. tion *Title: CEO ng must be the Chief Ex- unt representative for t tion *Title Office n voided check and a let	xecutive Officer, Chief the checking account i e: ce Manager ter from your bank yo	*Email Address: email@email.co Financial Officer, Manag isted above. Also, a witr *Phone Numi 601-555-555	m ing Partner or Owner less signature must be ber: 5	and must be included
reasonable opportunity rity Contact Informa *Name: John Smith Note: Person signir an authorized acco below. ate Contact Informa *Name: Sally Smith *Email Address: email@email.cor Please upload or fax a designated bank accou We hereby authorize E entries in error, or adj financial institution nar to our account must co	v to act on it. tion *Title: CEO ng must be the Chief Ex- unt representative for t tion *Title office n voided check and a let unt information above. Succross & Blue Shield ustments for any credit ned below, and to credi mply with the provision	kecutive Officer, Chief the checking account l e: ce Manager ter from your bank ve d of Mississippi to initia entries in error, to ou it the same to such ac is of U.S. law.	*Email Address: email@email.co Financial Officer, Manag isted above. Also, a witr *Phone Numb 601-555-555 crifying the routing and a ate credit entries and to ur checking account as in count. We acknowledge rint link to print the form	m ing Partner or Owner less signature must be per: 5 inccount numbers relate initiate, debit entries fi idicated below at the o that the origination of that includes signatur	and must be included ad to your or any credit lepository ACH transactions e spaces. Sign
reasonable opportunity rity Contact Informa *Name: John Smith Note: Person signin an authorized acco below. Ate Contact Informal *Name: Sally Smith *Email Address: email@email.cor Please upload or fax a designated bank accou We hereby authorize E entries in error, or adj financial institution nar to our account must co After saving the inform the form and upload or PROVIDER hereby exe accent the Provider Au	v to act on it. tion *Title: CEO ng must be the Chief Ex- unt representative for t tion *Title Office n voided check and a let unt information above. Blue Cross & Blue Shield ustments for any credit ned below, and to credit omply with the provision hation entered in the file r fax including a voided scutes Provider Authoriz thorization Agreement	kecutive Officer, Chief the checking account l e: ce Manager ter from your bank ve d of Mississippi to initia entries in error, to ou it the same to such ac is of U.S. law. elds above, click the p check using the uploa	*Email Address: email@email.co Financial Officer, Manag isted above. Also, a with *Phone Numb 601-555-555 erifying the routing and a ate credit entries and to ur checking account as in count. We acknowledge rint link to print the form ad facility in the Main App Automatic Deposits by cl	m ing Partner or Owner less signature must be per: 5 initiate, debit entries for idicated below at the o that the origination of that includes signatur plication page. icking the box marked	and must be included included or any credit lepository ACH transactions e spaces. Sign I "I have read &
reasonable opportunity ity Contact Informa *Name: John Smith Note: Person signin an authorized acco below. Ite Contact Informal *Name: Sally Smith *Email Address: email@email.cor Please upload or fax a designated bank accou We hereby authorize E entries in error, or adj financial institution nar to our account must co After saving the inform the form and upload or PROVIDER hereby exe accept the Provider Au @ I have read & so	v to act on it. tion *Title: CEO ng must be the Chief Ex- unt representative for t tion *Titl Office n voided check and a let unt information above. Blue Cross & Blue Shield ustments for any credit ned below, and to credit omply with the provision hation entered in the file r fax including a voided scutes Provider Authoriz thorization Agreement	kecutive Officer, Chief the checking account I e: ce Manager ter from your bank ve d of Mississippi to initia entries in error, to ou it the same to such ac is of U.S. law. elds above, click the p check using the uplow ration Agreement For For Automatic Deposit	*Email Address: email@email.co Financial Officer, Manag isted above. Also, a with *Phone Numb 601-555-555 erifying the routing and a ate credit entries and to ir checking account as in count. We acknowledge rint link to print the form ad facility in the Main App Automatic Deposits by cl is" .	m ing Partner or Owner less signature must be per: 5 initiate, debit entries for initiate, debit entries for idicated below at the or- that the origination of that includes signatur plication page, icking the box marked	and must be included included included or any credit lepository ACH transactions e spaces. Sign I "I have read &

Once the ACH agreement has been completed, click the "Save" button to continue.

Authorization Agreement for Automatic Deposits (Continued)

Once the ACH agreement has been saved, it must be printed, physically signed and electronically submitted with a voided check and a letter of verification from the bank. To print the ACH agreement, click the "Print" button on the Application Home Page.

Complete these online documents by 07/29/2012		
Documents	Last Activity Date	Status
 Mississippi Network Physician Application BCBSMS Key Physician Agreement AHS State Network Healthcare Professional Agreement Electronic Submission of Claims (ESC) Agreement Provider Remote System Access Agreement Authorization Agreement for Automatic Deposits 	07/26/2012 07/26/2012 07/26/2012 07/26/2012 07/26/2012 07/26/2012	Completed <u>View Information</u> Completed <u>View Information</u> Completed <u>View Information</u> Completed <u>View Information</u> Completed <u>Print</u>

After you click the "Print" button, the ACH agreement will open as a PDF document with the information entered listed in the appropriate fields. Once the ACH agreement has been printed, the form must be physically signed by the Authority Contact and a witness. **The signed ACH form should then be submitted with a voided check and a letter of verification from the bank.**

AUTHORIZATION AGREEMENT FOR AUTOMATIC DEPOSITS

We hereby authorize Blue Cross & Blue Shield of Mississippi to initiate credit entries and to initiate, if necessary, debit entries for any credit entries in error, or adjustments for any credit entries in error, to our checking account as indicated below at the depository financial institution named below, and to credit the same to such account. We acknowledge that the origination of ACH transactions to our account must comply with the provisions of U.S. law.

X Initial Request	Change Request	Effective Date of Change:
Type of account:	Checking 🗌 Savings	
Company Name: ACME M	IEDICAL CLINIC	Provider Identification #:
Depository (Bank) Name:	TATE BANK	Branch: DOWNTOWN
City: JACKSON		State: MS ZIP: 39211
Transit/ABA#: 123456789		A ccount #: 0123456789
Tax Identification #: 98765	4321	
X Please check here if thi	s banking information applies to	all tax identification numbers associated with your practice.
This authority is to remain i cation from us of its termin Depository a reasonable op	n full force and effect until Blue ation in such time and in such m portunity to act on it.	e Cross & Blue Shield of Mississippi has received written notifi- nanner as to afford Blue Cross & Blue Shield of Mississippi and
Name: JOHN SMITH		
Title: CHIEF FINANCIA	L OFFICER	
Signature:		Date:
Email Address: EMAIL@I	EMAIL.COM	
Note: Person signing my representative for	ast be the Chief Financial Offi the checking account listed a	icer or Managing Partner and must be an authorized account bove. Also, a witness signature must be included below.
Witness:		Date:
Please indicate below altern contact someone other than	ate contact information for your the Chief Financial Officer or N	r facility/office if Blue Cross & Blue Shield of Mississippi should Managing Partner regarding this project.
Name: SALLY SUE SMIT	н	Title: OFFICE MANAGER
Phone Number: 601555555	5	Email Address: _EMAIL@EMAIL.COM

Please obtain a letter from your bank verifying the routing and account numbers related to your designated bank account.

Supporting Documentation

. . . .

Once the application and the agreements have all been completed, supporting documentation will need to be provided for review. Please refer to the Network Criteria Information link to determine what information is required to be submitted for review. It is imperative that all the necessary supporting documentation is provided prior to submission to prevent any unnecessary delays in the application review process.

A listing of all required documents is available under 'Documents to Upload' for you to ensure all necessary supporting documents are provided. To upload the necessary documents for review, click the "Upload Documents" link listed to the right of the corresponding document. To submit additional documentation that is not listed in the 'Documents to Upload' section, click the link near the bottom of the section to submit other additional documents.

Provider Credentialing - Physic	cian	<u>Cli</u>	<u>ck Here for Network Criteria</u>
NAME: Doe, John	NPI ID: 1376754002	Тах	: ID: 753198932
1 Complete these online documents by 07/29	/2012		
Documents	Last Act	tivity Date	Status
Mississippi Network Physician Application BCBSMS Key Physician Agreement AHS State Network Healthcare Professional Agreement Electronic Submission of Claims (ESC) Agreement Provider Remote System Access Agreement Authorization Agreement for Automatic Deposits Supporting Documentation	07/20 07/20 07/20 07/20 07/20 07/20	6/2012 6/2012 6/2012 6/2012 6/2012 6/2012 6/2012	Completed <u>View Information</u> Completed <u>View Information</u> Completed <u>View Information</u> Completed <u>View Information</u> Completed <u>Print</u>
Some documents related to your practice are necessary. Othe documentation for your application.	rs may be necessary based on the spec	ifics of your practice. I	Please Upload or Fax all applicable supporting
Documents to Upload	Las	t Activity Date	
Certificate of Liability Insurance Claim History or National Practitioner Data Bank Report State License DEA Certificate Hospital Privileges CLIA Certificate/Waiver Curriculum Vitae Medicare/Medicaid Provider Number(s) Authorization Agreement for Automatic Deposits Electronic Submission of Claims (ESC) Agreement W-9 Form <u>Click here to download the required W-9 form</u> Upon completed Click here to submit other additional documents.	etion, sign and upload or fax. x cover sheet.	N/A N/A N/A N/A N/A N/A N/A N/A N/A	Upload documents Upload documents
3 Submit Application Packet for Credentialing	1		
Please click the button below to submit the application packe than viewing the submitted information.	t. After you submit the application packe	et you will not be allowe	ed to make any changes to the application othe

Note: Providers that do not have the ability to upload supporting documents may print a specialized fax cover sheet and fax in the necessary supporting documentation.

Submit Application

Back to View Applications

Uploading Supporting Documentation

Once you click the 'Upload Documents' link, an upload box will appear.

Upload Supporting Documentation
Please upload the supporting documents for State License
 Click the 'Browse' button to browse your system for the file. Select the file to upload (Max file upload size is 10MB) Click the 'Upload Documentation' button to upload the file.
Browse
List of Documents Uploaded for State License
There are no Documents to display
Close

Click the 'Browse' button to select the corresponding file on your system that you wish to provide as supporting documentation for your application. Once you have selected the corresponding file, click the 'Open' button to return to the upload box.

Choose file		?×
Look in:	🔁 Support Doc 🔹 🛨 🖽 🖝	
My Recent Documents Desktop My Documents My Computer	 ACH Agreement.doc Additional Info.txt CLIA Cert.bmp e-File Agreement.docx Malpractice1.pdf Malpractice2.xls Malpractice3.xlsx Notes.rtf Professional Liability.pdf State License.tif Test Image Doc1.GIF Test Image Doc2.PNG Test Image Doc3.JPG W9.pdf 	
My Network Places	File name: Files of type: All Files (*.*)	Dpen Cancel

Uploading Supporting Documentation (Continued.)

After you have selected the appropriate file, click the "Upload Documentation" button to upload the file. Once the file has been uploaded, there will an option to view the uploaded document to ensure the appropriate document was uploaded and to remove the document if the incorrect document was uploaded.

If you have more than one file that needs to be provided for supporting documentation, click the 'Browse' button again to select any additional files on your system that you wish to provide as supporting documentation for your application.

Upload Supporting Documentation		×
	Please upload the supporting documents for Certificate of Liability Insurance	
 Click the 'Browse' button to brows Select the file to upload (Max file Click the 'Upload Documentation' I 	e your system for the file. upload size is 10MB) outton to upload the file.	
Browse	Upload Documentation	
	List of Documents Uploaded for Certificate of Liability Insurance	
1. <u>View Professional Liability.pdf</u>	Remove Professional Liability.pdf	
	Close	1.

Once you have uploaded all necessary supporting medical documentation, click the 'Close' button to return to the Provider Application Home Page. Once the documentation has been uploaded, the link will show as "View Documents." The date of the last activity on the document will also be listed.

2 Supporting Documentation Some documents related to your practice are necessary. Others may be necessary based on the specifics of your practice. Please Upload or Fax all applicable supporting documentation for your application. Documents to Upload Last Activity Date Certificate of Liability Insurance 07/26/2012 View documents Claim History or National Practitioner Data Bank Report N/A Upload documents N/A Upload documents State License DEA Certificate N/A Upload documents Hospital Privileges N/A Upload documents CLIA Certificate/Waiver N/A Upload documents Curriculum Vitae N/A Upload documents Medicare/Medicaid Provider Number(s) N/A Upload documents Authorization Agreement for Automatic Deposits N/A Upload documents Electronic Submission of Claims (ESC) Agreement N/A Upload documents W-9 Form N/A Upload documents Click here to download the required W-9 form Upon completion, sign and upload or fax.

Click here to submit other additional documents.

If you are unable to upload documents, please click here for fax cover sheet.

Faxing Supporting Documentation

If you are unable to upload the necessary supporting documentation, you will need to fax the supporting documentation using the specialized fax cover sheet provided. Simply click the link for the fax cover sheet and print the fax cover sheet prior to submitting your application. Once you have submitted your application, fax the supporting documentation immediately to prevent any delays in handling your application. If the supporting medical documentation is not received within 24 hours of application submission, your application will be closed without review.

Provider Credentialing - Physician

3 Submit Application Packet for Credentialing

Click Here for Network Criteria

NAME: Doe, John	NPI ID: 1376754002	Т	ax ID: 753198932
Complete these online documents by 07	/29/2012		
Documents		Last Activity Date	Status
 Mississippi Network Physician Application 		07/26/2012	Completed View Information
BCBSMS Key Physician Agreement		07/26/2012	Completed View Information
3. AHS State Network Healthcare Professional Agreement		07/26/2012	Completed View Information
4. Electronic Submission of Claims (ESC) Agreement		07/26/2012	Completed View Information
5. Provider Remote System Access Agreement		07/26/2012	Completed View Information
6. Authorization Agreement for Automatic Deposits		07/26/2012	Completed Print
2 Supporting Documentation			. —

Some documents related to your practice are necessary. Others may be necessary based on the specifics of your practice. Please Upload or Fax all applicable supporting documentation for your application.

Documents to Upload	Last Activity Date	
Certificate of Liability Insurance Claim History or National Practitioner Data Bank Report State License DEA Certificate Hospital Privileges CLIA Certificate/Waiver Curriculum Vitae Medicare/Medicaid Provider Number(s) Authorization Agreement for Automatic Deposits Electronic Submission of Claims (ESC) Agreement W-9 Form	N/A N/A N/A N/A N/A N/A N/A N/A N/A	Upload documents Upload documents
Click here to download the required W-9 form Upon completion, sign and upload or fax.		
Click here to submit other additional documents.		
If you are unable to upload documents, please click here for fax cover sheet.		

Please click the button below to submit the application packet. After you submit the application packet you will not be allowed to make any changes to the application other than viewing the submitted information.

Back to View Applications Submit Application

Faxing Supporting Documentation (Continued)

Any supporting documentation that is faxed must be faxed using the specialized fax cover sheet provided. The specialized fax cover sheet contains a bar code unique to your application. This bar code ensures any faxed supporting documentation is appended to the appropriate application packet. Failure to use the specialized fax cover will result in delays in the processing of your application.

	It's good to be Blue.
	Provider Credentialing
	Fax Cover Sheet
ATTE	NTION: CREDENTIALING TEAM
FROM	I: ACME Medical Clinic
PROV	IDER TYPE:
Phy	ysician
TAX I	D: 7654321
20	104521
For the the set is the set of the	is documentation to be processed in a timely and accurate manner, please follow nstructions:
1)	Print this page.
2)	Place this sheet on top of the requested information.
3) 	Fax this cover sheet with requested information to 601-664-5120.
1)	e to follow these instructions may result in a delay in processing. Documentation submitted under this fax cover sheet must be applicable to the specific
	provider above.
2)	Only this fax cover sheet may be used for faxing the requested information for this provider.
	Confidentiality and Privacy Notice
The inform product do the use of responsible strictly pro All recipier	ation contained in this message, and stachments hereto, is confidential and it may be subject to attorney/client privilage or the attorney work ottine, and may contain Protected Health Information that is subject to use and disclosure restrictions under federal law. It is intended only for the individual or entity named above. If the secipient or reader of this message is not the intended recipient, or the employee or agent to deliver this message to the intended recipient, you are hereby notified that may dissemination, distribution or copying of this message is habited. If you have received this message in error, please notify us immediately so that we may arrange for the return of the original material, are expected to maintain appropriate protections on the information bereis.
	Blue Cross & Blue Shield of Mississicei, A Mutual Insurance Company,

Application Submission – New Provider

Once you have completed the application, any applicable agreements and uploaded the necessary supporting documentation (or printed the fax cover sheet), the application packet is ready to be submitted for credentialing review. To submit the application packet, click the "Submit Application" button located at the bottom of the screen.

Provider Credentialing - Physician

Click Here for Network Criteria

NAME: Doe, John	NPI ID: 1376754002	Tax ID: 753198932
Complete these online documents by 07/2 Documents	29/2012 Last Activity Date	Status
 Mississippi Network Physician Application BCBSMS Key Physician Agreement AHS State Network Healthcare Professional Agreement Electronic Submission of Claims (ESC) Agreement Provider Remote System Access Agreement Authorization Agreement for Automatic Deposits 	07/26/2012 07/26/2012 07/26/2012 07/26/2012 07/26/2012 07/26/2012	Completed <u>View Information</u> Completed <u>View Information</u> Completed <u>View Information</u> Completed <u>View Information</u> Completed <u>View Information</u> Completed <u>Print</u>

2 Supporting Documentation

Some documents related to your practice are necessary. Others may be necessary based on the specifics of your practice. Please Upload or Fax all applicable supporting documentation for your application.

Documents to Upload	Last Activity Date	
Certificate of Liability Insurance	07/26/2012	View documents
Claim History or National Practitioner Data Bank Report	07/26/2012	View documents
State License	07/26/2012	View documents
DEA Certificate	07/26/2012	View documents
Hospital Privileges	07/26/2012	View documents
CLIA Certificate/Waiver	07/26/2012	View documents
Curriculum Vitae	07/26/2012	View documents
Medicare/Medicaid Provider Number(s)	07/26/2012	View documents
Authorization Agreement for Automatic Deposits	07/26/2012	View documents
Electronic Submission of Claims (ESC) Agreement	07/26/2012	View documents
W-9 Form	07/26/2012	View documents
Click here to download the required W-9 form Upon completion, sign and upload or fa	Х.	

Click here to submit other additional documents.

If you are unable to upload documents, please click here for fax cover sheet.

3 Submit Application Packet for Credentialing

Please click the button below to submit the application packet. After you submit the application packet you will not be allowed to make any changes to the application other than viewing the submitted information.

	Back to View Applications	Submit Application	
to submission, the applic	ation and any applica	ble agreements	must be completed. Also,
e verify all required sunn	orting documentation	has been unload	led or is being faxed to

Prior to submission, the application and any applicable agreements must be completed. Also, please verify all required supporting documentation has been uploaded or is being faxed to prevent any delays in the processing of your application. If any required supporting documentation is not provided at the time of submission, the missing supporting documentation will be requested through *my*Notifications and the provider will have 10 calendar days to provide the requested information or the application will be closed without further review. Please refer to the following "Application Status – Additional Information Required" section of this document for more information on providing requested information.

Application Submission – New Provider (Continued)

After clicking the "Submit Application" button, you will need to indicate whether all the necessary supporting documentation has been uploaded or if additional documentation will be faxed to finalize the submission process. This will ensure your application is not rejected due to missing documentation that is in the process of being faxed for review.

Before You Submit	the Application:
Please select one of the optic	ons before submitting the application.
O Completed Application	- Uploaded Supporting Documents
O Completed Application	- Pending Fax Documents
	Submit Application Cancel

Once you have finalized the submission process, you will receive a verification message acknowledging the receipt of the application. This message will also include a link to the Provider Credentialing Home Screen if you need to submit another new provider application.

Information:
Your request has been received by Blue Cross & Blue Shield of Mississippi. You may check the status of your request by clicking on the <i>my</i> Notifications section on the home page.
To submit another application, please click here.

myBlue Provider Home Page – Recredential Application Process

All current Participating Network Providers are required to be recredentialed every three years. A notification will be sent to all Network Providers notifying them that it is time for recredentialing 60 days prior to their renewal date. This notification will be sent through the *my*Notifications function of *my*Blue Provider.



Note: Access to the Provider Credentialing section of *my*Notifications will be automatically given to all Super Users. If you handle the provider credentialing for your clinic or organization and do not have access to the Provider Credentialing section of *my*Notifications, please contact your Super User to have your *my*Blue Provider profile updated. If additional assistance is needed to establish the appropriate *my*Notifications access, please contact our EDI Services Department at 1-800-826-4068.

myNotifications – Recredential Notifications

Notification of a provider's recredentialing requirement will be listed with a "Pending Recredentialing" status. These notifications will be valid for 60 days from the date of creation. If a completed recredentialing application is not received within 60 days, the provider will be subject to termination from the network(s) and will be required to re-apply for future network participation.

myNotifications

Appeal	s M	edical Records	Prior /	Authorization	Provider Cre	dentialing					
Pro	Provider Credentialing										
	Searc	h Options —									
		Status All				•	NPI		Tax	KID All 👻	
	L L	Inopened 🔽					Date From		Date	e To	
											_
Sea	arch	Reset									
-											
5	earc	n Results									
8 rec	ords to	ound, displaying	g all reco	ords.							
	ID	Last Update		Tax ID	NPI	Status		Provider Name		Provider Type	
	3610	11/15/2012 2	:00 PM	987654321	0123456789	Pending Recreder	ntialing	,	D	Physician	
	3603	11/14/2012 2	:00 PM	987654321	1234567890	Sent		John M. Doe, MI	D	Physician	
	3602	11/19/2012 2	:13 PM	987654321	0123456789	Pending F	Fax Receipt	John L. Smith, M	D	Physician	

To view the recredentialing information, click on the corresponding message to open the message detail. The message will contain a link to the Application Home Screen.

myNotifications

Printable V	ersion			Return to myNotificati
Message Info D: Create Date: Close Date: Status:	rmation 3611 11/15/2012 2:00 PM Pending Recredentialing	Provider Information Provider Name: John M. Doe, MD Provider Type: Physician Provider NPI: 1234567890 Provider ID: 987654321 Tax ID: 987654321	Network Request Type: Network:	Re-credential Both
Recreden	tialing Information			
It is time for y Please click <u>h</u>	you to regredential your provide	r(s) with BCBSMS and/or the AHS network. here some information has already been pr	re-populated. Once you	ıstart

Provider Credentialing Home Screen – Existing Network Provider

The Provider Credentialing Home Screen will display a list of all open network provider applications based on your clinic's tax identification number. This screen will be bypassed if you click the link within the *my*Notifications message. The applications for providers that are due for recredentialing will be listed with a "Pending Recredentialing" status under My Provider Applications. Click on the applicable NPI number link of the provider that requires recredentialing to begin the recredentialing process.

		phications					
	© Tax	(ID © NPI ID ©)	All(list all requests f	for the User)	Search		
8 items four	nd, displaying	all items. 1					
<u>NPI</u>	Tax Id	Provider Name	Provider Type	<u>Network</u>	Credential Type	Status	Action
1234567890		e, MD	Physician	Both	Re-Credential	Pending Recredentialing	C bol
<u>9876543210</u>	987654321	Chad Chiro, DC	Chiropractor	BCBSMS	Re-Credential	Pending Recredentialing	Cancel Provider
0123456789	987654321	Jane Doe, FNP	Nurse Practitioner	Both	Re-Credential	Pending Recredentialing	Cancel Provider
1234567890	987654321	John Smith, MD	Physician	Both	Re-Credential	Pending Recredentialing	<u>Cancel</u> Provider
9876543210	987654321	Trapper John,	Physician	AHS	Re-Credential	Provider Started	Cancel Dravidar

Note: Providers that participate in both the BCBSMS and AHS Networks will have a network indicator of "Both" and will only have to complete the recredentialing process once for both networks.

Provider Application Home Screen – Existing Network Provider

Once you have accessed the application pending recredentialing, you will notice that the provider application is already in progress. This is already "in progress" because the information that is currently on file for this provider has been preloaded to the application for you to review and edit as necessary.

To complete the provider application, simply click on the application link.

Provider Credentialin	g - Physician	<u>Clicl</u>	<u>k Here for Network Criteria</u>
NAME: Doe, Jane	NPI ID: 1234567890		Tax ID: 987654321
1 Complete these online docume	ents		
Documents		Last Activity Date	Status
Mississippi Network Physician Application Electronic Submission of Claims (ESC) Ag Provider Remote System Access Agreeme Authorization Agreement for Automatic Dep	reen n ent posits	11/15/2012 N/A N/A N/A	In Progress Not Yet Started Not Yet Started Not Yet Started
2 Supporting Documentation			
Some documents related to your practice are supporting documentation for your application.	necessary. Others may be necessary i	based on the specifics of your pract	ice. Please Upload or Fax all applicable
Documents to Upload		Last Activity Date	
Certificate of Liability Insurance Claim History or National Practitioner Data Ba State License DEA Certificate Hospital Privileges CLIA Certificate/Waiver Curriculum Vitae Medicare/Medicaid Provider Number(s) Authorization Agreement for Automatic Depos Electronic Submission of Claims (ESC) Agree W-9 Form <u>Click here to download the required W-9 for</u>	nk Report its ment um Upon completion, sign and upload	N/A N/A N/A N/A N/A N/A N/A N/A N/A N/A	Upload documents Upload documents
Click here to submit other additional document	<u>ts.</u>		
t you are unable to upload documents, please	click here for fax cover sheet.		
3 Submit Application Packet for (Credentialing		
Please click the button below to submit the a application other than viewing the submitted in	oplication packet. After you submit the formation.	e application packet you will not be a	llowed to make any changes to the
	Back to View Applications	Submit Application	

Please remember that once an application has been started, it must be completed and submitted within three business days.

Provider Application – Existing Network Provider

The Provider Application for an existing network provider will be preloaded with certain information that is currently on file for the applicable network provider. The user will have the ability to update their existing provider information and provide any missing required information online. The user must complete the entire Provider Application before the recredentialing application packet can be submitted for review. Required fields will be indicated by an asterisk.

Once all the required information has been reviewed and updated as needed, the user will have to click the "Save & Continue" button at the bottom of the page to save the information and proceed to the next page of the application.

Page	1 of 22	Page 2 of	22 P	age 3 of 22	Page 4 of 22		Page 5 of 22	Page 6 of 22
n A -	I. IDENTIF	YING INFOR	MATION				-	
	*First Name:		Middle	Name:	*Last	Name:		Suffix:
	John				Doe			MD
	*Degree/Cer	tification:						
	MD	•						
	Is there any of have been kn	other name und	der which you	NDT.	Geoder:		*Date of Birth:	
		iown (ne Malde	in Norrie):	1234567890	Male C Female		11/15/1989	
				1201007000	(Used for consume	r	11/15/1909	
	Rith Blace C				information purpos	es only)		
		ATES			_			
	Birth Place Ci	ATES		Birth Place S	tate:			
	Jackson			MISSISSIP		1		
	Social Securit	ty Number:	Race/Ethnicity	(Ontional):	U.S. Citizen:			
	123456789			(optional)				
	Home Addres	s Line 1: St			Home Address Line	2:		
	City:	01		State:		Zin Code:		
	Jackson			MISSISSIP	기 🗸	39215		
	Email Addres	s:				00210		
	email@ema	il.com						
	Home Phone:		Home Fax:		Mobile Phone:			
	601-555-555	5	601-555-5555	5	601-555-5555			
	*Specialty:							
	General Pra	ictice	•					
	Subspeciality	:						
	Select Subs	pecialty	-					
	Subspeciality	:						
	Select Subs	pecialty	-					

Note: At any time during the application process, you may cancel the application and return at a later time to complete the application. However, you must "Save & Continue" to the next screen to prevent losing information that has already been entered. By clicking the "Save & Continue" button, you are saving your information. If any error messages exist, these messages must be resolved before the information can be saved. If you do not click "Save & Continue" before cancelling the application, any information entered on that page will be lost. **Reminder: Once a new application has been started, it must be completed and submitted within three business days.**

Provider Application – Existing Network Provider (Continued)

For the pages of the application where more than one set of information may apply, any information that is on file for the network provider will be listed as an existing record. In these situations, the user will need to review each existing record(s) to verify all information is still accurate. To review the record, click the "Edit" link and the information contained in the corresponding record will be populated in the appropriate fields for that page. Once the information has been updated and/or any missing required information has been provided, click the "Add" button to save the changes.

For existing network providers, only the practice locations associated with the available tax identification numbers will be pre-populated on this screen. If the provider practices at additional locations associated with tax identification numbers that are not listed, these locations must be listed later in the application under work history.

Once all the existing records have been reviewed and updated as needed, click "Save & Continue" to proceed to the next page of the application.

FIR	st Noffie;			Last Name:		
*F	hone:	Extension:	Fax:	Back Offic	ce/Business Office Pho	one:
*Is your office h	andicap accessible	? OYes	⊙No *Do you	have 24-hour cov	verage? 🔘 Yes 🕷) No
*Does your offic patients?	e accept new	O Yes	◎ No *Is your certain a	practice limited to ges?	patients of 🔘 Yes (No
		Office Ho	urs (12 Hour Clock Fo	ormat - HH:MM)		
Monda	у		-	Closed		
Tuesda	ıy -		-	Closed 🔲 Sa	ame as Previous Day	
Wedness	lay -		-	Closed 🔲 Sa	ame as Previous Day	
Thursda	ay -		-	Closed 🔲 Sa	ame as Previous Day	
Friday	·		-	Closed 🔲 Sa	ame as Previous Day	
Saturda	ау –		-	Closed 🔲 Sa	ame as Previous Day	
Sunda	у		-	Closed 🔲 Sa	ame as Previous Day	
Holiday	/s -		-	Closed 🔲 Sa	ame as Previous Day	
			Add Practice Loca	tion		
List of Practices ente	red					
	Practice Name	Start Date	Group NPI	Edit	Delete	
	 ACME Medical Clinic 	10/01/2012	1234569789	<u>Edit</u>	<u>Delete</u>	

Note: If the existing information is no longer valid, the user will have the ability to delete the invalid record.

Additional Provider Agreements – Existing Network Provider

BCBSMS and/or AHS Networks Providers are required to file claims electronically, receive payments electronically and have access to *my*Blue Provider. Although these agreements should already be on file for Network Providers, verification will be required prior to submitting the provider recredentialing application for review. If any of these agreements are not currently on file, a completed agreement will be required prior to submitting the provider model.

To verify if these agreements are on file, click on the link for each of the corresponding agreements.

1 Complete these online documents by 09/02/2012								
Documents	Last Activity Date	Status						
 Mississippi Network Physician Application Electronic Submission of Claims (ESC) Agreement Provider Remote System Access Agreement Authorization Agreement for Automatic Deposits 	08/30/2012 N/A N/A N/A	Completed <u>View Information</u> Not Yet Started Not Yet Started Not Yet Started						

Electronic Submission of Claims Agreement

Based on the provider's tax identification number, if an electronic claims submission agreement is already on file, a message will be received and an agreement will not be required.

Agreement For Electronic Claims Submission						
Our records indicate you already have an Electronic Submission of Claims agreement on file. No further action is required. Click Done to complete the process.						
Done						

For information on completing an Electronic Submission of Claims agreement, please refer to the previous "Electronic Submission of Claims Agreement" section of this document.

Remote System Access Agreement

Based on the provider's tax identification number, if a Remote System Access agreement is already on file, a message will be received and an agreement will not be required.

Provider Remote System Access Agreement						
Our reco further	Our records indicate you already have a Remote System Access agreement on file. No further action is required. Click Done to complete the process.					
Done						

For information on completing a Remote System Access agreement, please refer to the previous "Remote System Access Agreement" section of this document.

Authorization Agreement for Automatic Deposits

To verify if an Authorization Agreement for Automatic Deposits (ACH) agreement is already on file, the Voucher ID must be selected. The Voucher ID is the number associated with the Provider Remittance Statement. In most cases, this number will be related to the tax identification number.

ACH Setup							
To verify if an Authorization Agreement for Automatic Deposit (ACH) is already on file, please select the Voucher ID associated with your tax identification number and click "Continue". The Voucher ID is listed on the your provider remittance statement near the top of each page and is based on your tax identification number. If multiple locations exist, an alpha suffix is appended to the Voucher ID for each location. If applicable, please ensure to select the Voucher ID with the appropriate alpha suffix.							
*Voucher Id:	Select Voucher ID 🔻	Continue Cancel					

Once the Voucher ID is selected, click "Continue" to verify if an ACH agreement is already on file. If an agreement is already on file, a message will be received that ACH information is already on file. If this message is received, an ACH agreement will not be required. Click "Done" to return to the Provider Application Home screen.

ACH Setup							
*Voucher Id: ACH Information	987654321 on file - Click "	▼ Update ACH" butt	on to update informa	tion or "Done	" to complete s	etup.	
		Continue	Update ACH	Done	Cancel		

Note: If ACH information is already on file, the user can update the ACH information if needed. An updated ACH form, however, will be required to be submitted along with supporting banking documentation.

If an agreement is not already on file, you will be taken directly to the electronic ACH agreement for completion. For information on completing an ACH agreement, please refer to the previous "Authorization Agreement for Automatic Deposits" section of this document.

Supporting Documentation – Existing Network Provider

Once the application and any applicable agreements have been completed, updated supporting documentation will need to be provided for review. Please refer to the Network Criteria Information link to determine what information is required to be submitted for network review. It is imperative that all necessary supporting documentation is provided prior to submission to prevent any unnecessary delays in the application recredentialing process.

To upload the necessary documents for review, click the "Upload Documents" link listed to the right of the corresponding document.



If you are unable to upload documents, please click here for fax cover sheet.

Note: Providers that do not have the ability to upload supporting documents will be able to print a specialized fax cover sheet and fax in the necessary supporting documentation.

For more information on uploading or faxing supporting documentation, please refer to the previous "Uploading Supporting Documentation" and "Faxing Supporting Documentation" sections of this document.

Once you have completed the application, any applicable agreements and uploaded the necessary supporting documentation (or printed the fax cover sheet), the application packet is ready to be submitted for recredentialing review. To submit the application packet, click the "Submit Application" button located at the bottom of the screen.



For more information on submitting you application for review, please refer to the previous "Application Submission" section of this document.

Provider Credentialing Home Screen – Provider No Longer With Clinic

In some cases, the existing network provider may no longer be with the clinic receiving the recredentialing notice. In this case, the user has the ability to cancel the provider's recredentialing application. To cancel a provider's recredentialing application, click the "Cancel Provider" link listed under the Action column.

My Provider Applications										
	© Tax ID ◎ NPI ID ◎ All(list all requests for the User)									
8 items four	8 items found, displaying all items.1									
<u>NPI</u>	<u>Tax Id</u>	Provider Name	Provider Type	<u>Network</u>	Credential Type	<u>Status</u>	Action			
1234567890	987654321	John Doe, MD	Physician	Both	Re-Credential	Per	<u>Cancel</u> <u>Provider</u>			
<u>9876543210</u>	987654321	Chad Chiro, DC	Chiropractor	BCBSMS	Re-Credential	Pending Recredentialing	Cancel Provider			
0123456789	987654321	Jane Doe, FNP	Nurse Practitioner	Both	Re-Credential	Pending Recredentialing	<u>Cancel</u> Provider			
<u>1234567890</u>	987654321	John Smith, MD	Physician	Both	Re-Credential	Pending Recredentialing	Cancel Provider			
9876543210	987654321	Trapper John, MD	Physician	AHS	Re-Credential	Provider Started Application	<u>Cancel</u> Provider			

To cancel a provider's recredentialing application, the date of termination and the reason for termination will be required. A contact name will also be required in case additional information is needed. Once the additional information has been provided, click "Save" to continue.

CANCE	PROVIDER APPLICATION	
Provide	r Information Provider Name:	Contact Name:
	John Doe, MD	Sally Sue Smith
	Termination Date: Reason for Termination: 09/30/2011 Select Reason	•
		Save

Note: Blue Cross & Blue Shield of Mississippi should be notified immediately when an existing network provider leaves a clinic for any reason. The "Cancel Provider Application" function should not be used as the primary means of notification. Notifications of termination should be sent with a completed 'Provider Administration Communication Form' to <u>providerdatabase@bcbsms.com</u>. The 'Provider Administration Communication Form' is available under the Form Download section of *my*Blue Provider.

Application Status – myNotifications

After you have submitted the application and provided all the necessary supporting documentation, the status of the application will be available through *my*Notifications under Provider Credentialing.



Welcome to the new m_y Blue Provider web portal! With m_y Blue Provider, you can expect all the same great features as before with an enhanced appearance and easier access to information. Our commitment to you includes providing you with the most efficient tools to manage our partnership and to provide the Value of Blue in all that we do. Click the headline for additional information.

Application Status – myNotifications (Continued)

Upon entering the Provider Credentialing section of *my*Notifications, all unopened messages will be displayed. If the application you are searching for is not listed, you will have the ability to search all applications submitted using the search options provided.

Based on the status of the message, you will be able to determine if your application has been sent for review, if it is in the process of being reviewed, if additional information is needed for review or if the review of your application has been completed. It is important to monitor any outstanding applications daily to ensure any requested additional information is provided promptly.

Provider Credentialing								
	Searc	h Options						
		Status All			▼ NPI		Tax ID All 👻	
	U	Inopened 🔽			Date From		Date To	
Sea	Search Reset							
S	earc	h Results						
8 rec	ords f	ound, displaying all reco	ords.					
	ID	Last Update	Tax ID	NPI	Status	ler Name	Provider Type	
\$	3610	11/15/2012 2:00 PM	987654321	0123456789	Pending Recredentialing	Sally S. Smith, OD	Physician	
^	3603	11/14/2012 2:00 PM	987654321	1234567890	Sent	John M. Doe, MD	Physician	
	3602	11/19/2012 2:13 PM	987654321	0123456789	Pending Fax Receipt	John L. Smith, MD	Physician	
^	3599	11/12/2012 7:41 PM	987654321	1234567890	In Process	John M. Doe, OT	Occupational Therapist	
\$	3598	11/12/2012 7:41 PM	987654321	0123456789	Additional Information Required	Thomas A. Jones, LMSW	Licensed Master Social Worker	
\$	3597	11/12/2012 7:41 PM	987654321	1234567890	Additional Information Sent	Jane R Doe, FNP	Nurse Practitioner	
	3596	11/12/2012 7:41 PM	987654321	0123456789	Complete	John M. Doe, MD	Physician	
	3595	11/12/2012 7:41 PM	987654321	1234567890	Pending Recredentialing	Chad T. Chiro, DC	Chiropractor	

A complete listing of the different statuses and what each status means is provided below. Please note the statuses with an '*' require action from you.

- *Pending Recredentialing: The existing network provider needs to renew their network status.
- Sent: Completed application packet with supporting documentation has been sent for review.
- Pending Fax Receipt: Completed application received but BCBSMS is still awaiting the receipt of faxed supporting documentation. Supporting documentation should be faxed in immediately to prevent the application from being closed for non-receipt of the supporting documentation.
- In Process: Completed application packet is currently in the credentialing process.
- *Additional Information Required: Additional supporting documentation or clarification of information entered is needed to complete the credentialing process. Requested additional information should be provided immediately to prevent the application from being closed for non-receipt of the requested information.
- Additional Information Request Cancelled: Additional documentation is no longer needed.
- Additional Information Sent: Requested additional information received and sent for review.
- Complete: Provider credentialing process has been completed.
- Closed Not Completed Timely: Provider credentialing process discontinued due to non-receipt of supporting documentation or requested additional information.

Application Status – Additional Information Required

If during the review of your application, additional information is determined to be needed, the information will be requested through *my*Notifications and the message will be listed with an "Additional Information Required" status. To determine what additional information is needed for review, click the corresponding message to view the request.

	ID	Last Update	Tax ID	NPI	Status	Provider Name	Provider Type
슯	3610	11/15/2012 2:00 PM	987654321	0123456789	Pending Recredentialing	Sally S. Smith, OD	Physician
	3603	11/14/2012 2:00 PM	987654321	1234567890	Sent	John M. Doe, MD	Physician
	3602	11/19/2012 2:13 PM	987654321	0123456789	Pending Fax Receipt	John L. Smith, MD	Physician
	3599	11/12/2012 7:41 PM	987654321	1234567890	In Process	John M. Doe, OT	Occupational Therapist
	3598	11/12/2012 7:41 PM	987654321	0123456789	Additional Information	MSW	Licensed Master Social Worker
â	3597	11/12/2012 7:41 PM	987654321	1234567890	Additional Information Sent	Jane R Doe, FNP	Nurse Practitioner
	3596	11/12/2012 7:41 PM	987654321	0123456789	Complete	John M. Doe, MD	Physician

The additional information needed for review will be listed in the "Request" section of the Application Detail Screen. The "Request" section will also provide you with the ability to either upload the requested additional information or print a specialized fax cover sheet to fax the requested additional information. If the information requested in not available, you can respond to the request with a detailed explanation as to why the requested information is not available. If the requested additional information is not received within 10 calendar days of the request, the application will be closed without further review.

Provider Ci	redentialing		
Printable Ve	ersion	Return to myNotifications	
Message Info ID: Create Date: Close Date: Status:	rmation 3647 11/27/2012 5:39 PM Additional Information Required	Provider Information Provider Name: John Doe, MD Provider Type: Physician Provider NPI: 1234567890 Provider ID: Tax ID: 987654321	Network Request Type: Initial Network: Both
Request The following ini Claims H Please Upload Docum	formation is needed to complete cred istory Report provide report nents Fax Documents Informat	entialing: ion Not Available	

Once the additional information has been uploaded or faxed, the status of the message will be updated to "Additional Information Sent" to indicate the requested information has been provided.

Note: If the requested information is not available, the processing of your application may be delayed or your application may be denied for not meeting the required network criteria.

Application Status – Complete

After the review of the application has been completed, an approval or denial/termination will be sent through *my*Notifications and the message will be listed with a "Complete" status. To determine whether or not your application was approved for network participation, click the corresponding message to view the response.



The response to your application for initial or continued network participation will be listed in the comments of the "Note Log" section of the Application Detail Screen. If your application was approved for network participation, the appropriate network approval letter(s) showing your network effective or renewal date will be provided in the "Attached Documentation" section. For new providers, the appropriate signed network agreement(s) will also be provided. If your application was denied for initial or continued network participation, the appropriate network denial/termination letter showing the reason for the denial/termination will be provided. For existing providers that have their network status terminated, the termination letter will include the effective date of their network termination.

rovider Credent	ialing						
Printable Version	Printable Version						
Message Information ID: 3641 Create Date: 11/27/20 Close Date: Status: Complete	12 4:47 PM	Provider Information Provider Name: John Doe, MD Provider Type: Physician Provider NPI: 1234567890 Provider ID: Tax ID: 987654321	Network Request Type: Initial Network: Both				
Attached Docur • BCBS Approval.pdf • BCBS Signed agreem • AHS Approval.pdf • AHS Signed agreeme Note Log	nentation]					
Туре	Date	Comment					
Update from BCBSMS 11/28/2012 9:42 AM		The BCBSMS credentialing team has completed the application credentialing process. Please reference the attached document(s) for details.					

Providers that are denied network participation or had their network status terminated, may reapply for network participation once all network criteria has been met.

If you have any questions regarding the network credentialing process, please contact us via the Contact Blue function of *my*Blue Provider. If you need any assistance establishing the appropriate *my*Blue Provider access, please contact our EDI Services Department at 1-800-826-4068.