

Durable Medical Equipment (DME) Facility Check List and Credentialing Application



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Please complete every section of the attached form. The following list may be used as a reference to assist you with the application. Recredentialing is conducted every three years and unless you are notified, participation will remain effective with no gaps.

DME Facility Information

Malpractice/Liability Insurance: Attach the malpractice insurance certificate or face sheet and evidence on letterhead (e.g. roster, letter, or fax) which clearly states that the provider, facility, or institution is covered by the insurance policy. The face sheet will also need to include the name of insurance company, from and through dates, policy number, and occurrence/aggregate amounts.

Signed Attestation

Requirements: Medicare Certification or Medicare Participation. Notify BCBSND of any changes to your Medicare status as it may affect your credentialing and/or continued participation.

If you have any questions, please call 800-756-2749 or send an email to prov.net@bcbsnd.com.

DME Facility Information <i>(Please complete a separate application for each location)</i>			
Name of Facility		Federal TIN	
Medicare Certification # or Medicare Participation #		Taxonomy Code	
Physical Street Address (Street, City, State, Zip)		Billing/Mailing Address (Street, City, State, Zip) <i>(If different from physical address)</i>	
Street		Street	
City	State	Zip	
City	State	Zip	
Office Phone #	Office Fax #	Billing Telephone #	Billing Fax #
Office Staff Foreign Languages <input type="checkbox"/> Speak <input type="checkbox"/> Read <input type="checkbox"/> Write <input type="checkbox"/> N/A			
Business Office Contact Name		Business Office Email Address	
NPI Number	Date Business Opened	Name and Title of Chief Administrator	
Type of Facility/Ownership		Organizational Structure	
<input type="checkbox"/> Government (Federal, State, County, City) <input type="checkbox"/> Private Non-Profit <input type="checkbox"/> Private For Profit <input type="checkbox"/> Other:		<input type="checkbox"/> Corporation <input type="checkbox"/> Public Agency <input type="checkbox"/> Partnership <input type="checkbox"/> Group Practice Assoc. <input type="checkbox"/> Single Owner <input type="checkbox"/> Professional Corporation	
Malpractice/Liability Insurance			
Attach copy of malpractice certificate or face sheet.			

Release and Attestation

The undersigned is authorized to act on behalf of the institution/facility (Entity), and certifies that all information submitted on this application and all attachments hereto are correct, true and complete to the best of my knowledge.

The Entity consents to complete disclosure of and authorization to make available to Blue Cross Blue Shield of North Dakota (BCBSND), its affiliates or any of their agents, all relevant information pertaining to and deemed necessary and appropriate in the investigation and processing of this application, including but not limited to, information obtained through a third party such as an insurance company, licensing authority, accrediting agency or governmental agency.

The Entity releases and discharges BCBSND, its affiliates and their representatives, credentials committees, administrators, governing bodies, agents, employees and all other persons or entities supplying information to them, from liability or claims of any kind or character in any way arising out of inquiries or disclosures made in good faith in connection with this application.

The Entity agrees to update this application while it is being processed should there be any change in the information provided regarding the Entity that could affect the application or its outcome. A photocopy of this document shall be as effective as the original.

Name (Print or Type)	Title
Signature	Date (MM/DD/YYYY)

If you are having difficulty submitting the form once completed, please send using one of the following methods:

- **Email:**
 - **Click on "File" at the top of your screen**
 - **Click on "Save As"**
 - **Save the completed form on your computer**
 - **Attach the completed form to an email and send to providerforms@bcbsnd.com**
- **Fax: 701-282-1910**
- **Mail: 4510 13th Ave. S.
Fargo, ND 58121**