BLUE CROSS BLUE SHIELD OF RI (BCBSRI)
SPECIALTY/REIMBURSEMENT QUESTIONNAIRE

FOR NP (Nurse Practitioner) / PA (Physician Assistant)

NP/PA Name: _____

Location(s): _____

Location(s): _____

NOTE: This will be used to determine specialty which drives co-pays and reimbursement rates. Also, a separate Questionnaire is required for each practice if the NP/PA works at more than one practice. For practices with multiple offices please list all locations where NP/PA provides services.

1. Please indicate which ONE of the services you will be providing	
	OB/GYN
	Oncology
	Allergy/Immunization
	Dermatology
	Mental Health (CNS License)
	Behavioral Health (CNP License)
	Specialist (Internal Medicine Non PCP)
	PCP - Without member panel
	PCP - With member panel* ***Attached NP/PCP Panel Questionnaire must be completed***

_____

NP/PA Signature Date

_____

Please Print Name

BLUE CROSS BLUE SHIELD OF RI (BCBSRI)

NP/PA PCP with PANEL QUESTIONNAIRE

Please note that in addition to completing this form an NP/PCP requesting to open a member panel must undergo a medical office site visit and must be approved by the Professional Advisory & Credentials Committee

Nurse Practitioner/ Physician's Assistant PCP Name: _____

1. 24/7 on-call availability is required. Please provide a *detailed* plan below. (e.g. answering service, names of BCBSRI in-network covering providers, etc.)
2. **Please provide a *detailed* plan for BCBSRI Members admitted to inpatient setting. (List preferred in-network hospital(s), provider who will follow Member during admission, plan for your communication with covering provider(s) before, during and after discharge).**
3. **Please provide a *detailed* plan for post-discharge care below. (How will you ensure you receive notification when Member is discharged from inpatient setting and ensure a post-discharge plan of care is in place for Member).**
4. Please provide current DEA Number below
5. Please indicate which services you will be providing by checking one below

	Internal Medicine		Family Practice		Pediatrics

_____

NP/PA Signature Date

_____

Please Print Name