BlueCross BlueShield Nebraska

Provisional Provider Form

For use by PLMHP, PLADC, PLCSW, PCMSW, PPhD, PPsyD and RBT providers only

Email the completed form to HealthNetworkRequests@NebraskaBlue.com

Provider Information

Provider Name: _____ Phone Number: _____

Email Address: _____ Gender: _____

Individual NPI: _____ SSN: _____ DOB: _____

Nebraska License Number: _____ Provisional Supervisor: _____

Requested Effective Date: _____ Provisional Supervisor's NPI: _____

Must be a future date; otherwise, changes will apply to the date this form is received.

Supervisior must be credentialed and in-network with BCBSNE to be valid.

Clinic Group NPI: _____

Physical and Billing Address

Tax ID for Claim Filing: _____

A group agreement is required if this is a brand new Tax ID.
If you have questions, please contact the Provider Executive of the Supervisor.

Office Name: _____

Office Address: _____ City: _____ State: _____ ZIP: _____

Office Phone: _____ Office Fax: _____

Payment Name: _____

Billing Address: _____ City: _____ State: _____ ZIP: _____

Billing Phone: _____ Billing Fax: _____

Education History

School(s) Attended	Dates	Degree and Year Graduated

Specialty Information

Specialty: _____

Sub-specialty: _____

Professional Membership / Appointments:

Academic Appointments, Research, Publications:

Provider Name: _____ SSN: _____

Professional Experience - Past Five Years

Organization Name: _____

Address: _____

City: _____ State: ____ ZIP: _____

Start Date: _____ End Date: _____ Position Held: _____

Organization Name: _____

Address: _____

City: _____ State: ____ ZIP: _____

Start Date: _____ End Date: _____ Position Held: _____

Liability Insurance

Insurance Provider: _____

Provider's Address: _____

Policy Number: _____ Policy Limit(s): _____

Have there been any gaps in liability coverage in the past five years? ◯ Yes ◯ No

Do you have previous or pending judgments or settlements in liability cases? ◯ Yes ◯ No

Have you ever been convicted of, or plead guilty to, a felony or misdemeanor? ◯ Yes ◯ No

Has your license ever been relinquished, denied, suspended, revoked, restricted or limited? ◯ Yes ◯ No

If you answered "yes" to any of the above, please explain (include dates, reasons, results, etc.). If substance use, please provide a letter from a treating physician:

Attestation and Authorization

I certify that the above information is accurate and true, and I authorize any third party to release information concerning this application to Blue Cross and Blue Shield of Nebraska.

Signature: _____ Date: _____

Supervisor Signature: _____ Date: _____