BlueCross BlueShield Nebraska

Provider Pre-Qualify Questionnaire

Thank you for your interest in participating in the Blue Cross and Blue Shield of Nebraska (BCBSNE) provider network! Please complete and return this assessment to its sender at BCBSNE or to **CredentialingRequests@NebraskaBlue.com**.

We will respond once we have evaluated your facility's specific services in reference to our current network needs.

Note: This assessment is meant to determine your facility's eligibility to participate in the BCBSNE provider network. An offer will only be extended if it is determined that your facility meets the necessary requirements.

Facility Name: _____

Facility Contact: _____

Email: _____

Phone Number: _____

Mailing Address: _____

Is your facility a:

- ☐ Specialty Pharmacy
- ☐ Home Medical Equipment Supplier
- ☐ Independent Lab
- ☐ Mental Health (please specify the provider type):
  - ☐ RTC
  - ☐ IOP
  - ☐ Substance Abuse
- ☐ Other (please specify): _____

Facility's Tax Identification Number: _____

Facility's National Provider Identifier: _____

Facility's Medicare certification/provider number: _____

Does your facility currently hold a license to operate in the state of Nebraska?

☐ Yes ☐ No

If yes, what is the profession or specialty? _____

Are you licensed in the state where your facility is headquartered?

☐ Yes ☐ No

If yes, what is the profession or specialty? _____

Does your facility have physical (brick and mortar) locations in Nebraska?

☐ Yes ☐ No

If yes, please list the business name(s) and address(es):

_____

_____

_____

_____

What products or services differentiate your facility from other providers of the same specialty? Please be specific.

_____

_____

_____

_____

Please attach a copy of the codes you bill.

Have you filed claims to BCBSNE previously? ☐ Yes ☐ No

Do you contract with other Blue Cross and/or Blue Shield Plans? ☐ Yes ☐ No

If yes, what is the profession or specialty? _____

Date Completed: _____

Date Received by BCBSNE: _____

Thank you for taking the time to provide this information. We will follow up with an email notification advising whether or not you have been selected to move forward with the credentialing process. If your facility is selected to proceed, you will be sent an informational packet to complete. Please complete and return the packet to BCBSNE, with all requested supporting documents.