BlueCross BlueShield of Alabama

An Independent Licensee of the Blue Cross and Blue Shield Association

HEALTHCARE FACILITY APPLICATION

Completed form with supporting documents may be returned by fax or mail to:

Fax Attn: Facility Credentialing **1-205-220-9545**	**Mail** **Blue Cross and Blue Shield of Alabama,** Attn: Facility Credentialing Post Office Box 362142, Birmingham, AL 35236-2142	**Email** **credcross@bcbsal.org** with any questions.

Facility Type* *(Choose one facility type below for the enrolling facility and list subparts in Facility Subpart section.)*

A separate application will be required for each facility type with separate billing information including separate billing NPI.

☐ Ambulatory Surgery Center	☐ Federally Qualified Health Center (FQHC)	☐ Rural Health Clinic (RHC)
☐ Acute Care Hospital	☐ Long Term Acute Care Hospital	☐ Skilled Nursing Facility
☐ Dialysis Center	☐ Rehabilitation Hospital	☐ Veterans/Military Hospital

Fields denoted with an asterisk* must be completed.

General Facility Information

Facility Name*		Are you incorporated?* ☐ Yes ☐ No
Payment Tax ID/EIN Number*	Organizational Billing NPI Number*	Medicare Number*
Total Number of Beds? Specify number of each: ☐ Hospitals ☐ LTAC ☐ Rehabilitation Facilities		
Are your rooms Private ☐ or Semi Private ☐ ? If Semi Private what is the average room rate?		
License*	Issue Date*	Expiration Date*
Accreditation* *(Attach copy of most recent approval)*	Issue Date*	Expiration Date*
Contact Name*	Contact Email*	
Contact Phone Number*	Contact Fax Number*	

Facility Location Information *(Must have a street address – PO Boxes are not acceptable.)*

Street Address*		
City*	State*	Zip*
Main Switchboard Phone Number*	Main Fax Number*	

Correspondence Address *(For notifications, newsletters, etc.)*

Correspondence Address*		
City*	State*	Zip*
Correspondence Email*	Correspondence Phone Number*	Correspondence Fax Number*

Payment Address *(If different from location and correspondence address.)*

Payment Name*		
Payment Address*		
City*	State*	Zip*
Payment Contact Email*	Payment Phone Number*	Payment Fax Number*

Facility Subparts

For facilities that include subparts, please check all that apply (all units included under Tax ID/billing NPI of facility and not billing separately). If the operation or management of any subpart is contracted to another entity, please list entity to the right.

Subpart	Name of Entity/DBA	Subpart NPI if Available
☐ Psychiatric Unit		
☐ Rehabilitation Unit		
☐ Swing Bed Unit		

Ownership and/or Control*

Is the Management vested in the board?	
Chief Executive Officer (CEO) Name	Phone Number
Chief Financial Officer (CFO) Name	Phone Number
Full-time Medical Director Name*	Phone Number*
Medical Director Name*	Phone Number*

Liability Insurance*

Professional liability insurance, including coverage for any medical negligence or malpractice, in the minimum amounts of $1,000,000 per occurrence and $1,000,000 in the aggregate per calendar year. (Please note **general liability** coverage will not satisfy this requirement.)

General liability insurance or comprehensive public liability insurance, including coverage for accidents or other incidents causing injury to any person or property and occurring on or about the premises of Facility in the minimum amount of $200,000 per person per occurrence and $600,000 per occurrence per calendar year.

Requires authorized signature of the CEO or CFO.

I certify this information is complete and correct to the best of my knowledge.

Print Name _____ Title _____

Signature _____ Date _____

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FACILITY BUSINESS NETWORK INTEREST FORM

This form is required for all new applicants, providers being recredentialed and any provider interested in being added to a network. New providers must also complete an enrollment application found at **AlabamaBlue.com/Providers**. Providers adding a new location must submit this form to have Par Status added to the new location.

As a provider enrolling with Blue Cross and Blue Shield of Alabama, being recredentialed or adding a new location with a new tax ID, I would like to express my interest or continued interest in applying for the Provider Networks indicated. I understand expressing my interest in any of these programs is not an entitlement or guarantee of acceptance as a participant in any network offered by Blue Cross. I understand that prior to an offer to participate, my credentials will be verified along with the business need for additional providers in these networks.

✓	Network	Eligible Provider	Network Status
	Participating Ground Ambulance/All Kids/ Blue Advantage®	Ground Ambulance	Open
	Participating Air Ambulance/Blue Advantage	Air Ambulance	Open
	Participating Ambulatory Surgery Center	☐ Single Specialty ○ Multi-Specialty	Open
	Participating Dialysis	Dialysis	Open
	Preferred Medical Laboratory (PML)	Clinical Labs with CLIA Certification	Open
	Participating Hospital Network	Hospital	Open
	Blue Advantage – Medicare Advantage Program	☐ ASC ☐ DME ☐ Dialysis ☐ Home Health ☐ Hospital ☐ IDTF ☐ Laboratory ☐ RHC/FQHC ☐ SNF	Open
	Preferred Home Health Agency	Home Health Agency	Open
	Preferred Home Infusion Agency	Home Infusion Agency	Open
	Preferred Durable Medical Equipment (DME)	DME Supplier with physical facility within Alabama	Open
	Preferred Hospice Network	Hospice agency with AL Dept. of Health Certificate	Open
	NO – I am not interested in participating in any Blue Cross network.		

Provider Attestation

I have read and hereby agree to all the terms and conditions of each and every above-indicated Blue Cross and Blue Shield of Alabama network agreement(s) of which this Application is made a part of and incorporated in full therein. I have read and hereby agree to all of the other applicable network agreements and to all of the terms and conditions of the network(s) indicated. I support the intent of the Preferred Care Program(s) and will immediately notify BCBSAL if my practice or business is restricted in any manner. This includes, but is not limited to, restrictions by state(s) licensing body, by medical liability carrier, by hospitals, or by restrictions or limitations in dispensing drugs as licensed to provide. I understand that failure to support the program or report any practice or business restriction will be grounds for immediate removal from BCBSAL programs. I understand BCBSAL will provide its written decision on this Application.

Name of Facility/Business			
DBA		Organizational NPI	
Contact Name		Tax ID Number	
Email	Office Phone	Fax Number	
Location Address			
City	State	Zip	County
Mailing Address			
City	State	Zip	County
Signature	Title		Date

Submission Instructions

Fax: Fax the signed and completed form to: Attn: Credentialing **1-205-220-9545**	**Mail:** Blue Cross and Blue Shield of Alabama, Attn: Credentialing/Provider Data P.O. Box 362142, Birmingham, AL 35236-2142

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REQUEST FOR TAXPAYER IDENTIFICATION NUMBER
SUBSTITUTE FORM W-9

This form should be filled out completely. Please print.

Part 1: Tax Status			
Name as it appears on Internal Revenue Service (IRS) Records ***(Required)***			
Employer Identification Number	**(or)**	Social Security Number	**Effective Date**
If you are a Sole Proprietor or Single-owner LLC			
Personal name of owner of business ***(Required)***			
DBA (doing business as) if different from above ***(Optional)***			

Part 2: Exemption
If exempt from form 1099 reporting, you must include a copy of your IRS exemption letter.
1. Tax Exempt Entity under 501(a) (includes 501(c) (3)), or IRA; 2. The United States or any of its agencies or instrumentalities; 3. A state, the District of Columbia, a possession of the United States, or any of their political subdivisions; 4. A foreign government, or any of its political subdivisions.

Part 3: Certification
Under penalties of perjury, I certify that:
1. The number shown on this form is my correct taxpayer identification number, and 2. I am not subject to backup withholding because: a) I am exempt from backup withholdings, or b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or c) the IRS has notified me that I am no longer subject to backup withholdings, and 3. I am a U.S. person (including a U.S. resident alien). 4. I am exempt from FATCA reporting

Name of person completing this form			
Signature			**Date**
Telephone	Fax	E-mail *(optional)*	
Tax Address			
City	State	Zip	County

Instructions: The amounts we pay you may be reported to the Internal Revenue Service (IRS). The IRS will match this amount to your tax return. We are required by law to obtain your name and Taxpayer Identification Number. The name we need is **the name that is used on the tax return.**

U.S. person: This form may be used only by a U.S. person, including a resident alien. Foreign persons should furnish us with the appropriate Form W-8.

Penalties: Your failure to provide a correct name and Taxpayer Identification Number may subject your payments to 28% federal income tax backup withholding. If you do not provide us with this information, you may be subject to a $50 penalty imposed by the IRS under section 6723. If you make a false statement with no reasonable basis that results in no backup withholding, you are subject to a $500 civil penalty. Willfully falsifying certifications or affirmations may subject you to criminal penalties including fines and/or imprisonment.

Confidentiality: If we disclose or use your Taxpayer Identification Number in violation of Federal law, we may be subject to civil and criminal penalties.