



**Instructions**

<ul style="list-style-type: none"> <li>• Please PRINT or TYPE a response for each question.</li> <li>• Please attach the copies of the documents and any additional information requested.</li> <li>• Please indicate N/A if a question is not applicable.</li> </ul>		<ul style="list-style-type: none"> <li>• Please understand that these questions are asked of all participants</li> <li>• Your responses will be used by the Credentialing Committee and will remain confidential.</li> </ul>		
<input type="checkbox"/> Add New Provider	<input type="checkbox"/> Update Existing Provider Information	<input type="checkbox"/> Add a Location	<input type="checkbox"/> Update Existing Location	Effective Date of Change (MM/DD/YYYY)

**I. General Application Information**

**Check appropriate box:**

Initial Enrollment for Preferred or Participating Status     Blue Shield Provider Number     Change of Information     Change of Ownership/Tax ID

**If you are requesting initial enrollment for Preferred or Participating status, check the appropriate box:**

Preferred DME Supplier     Participating Hospice Provider     Participating Ambulance Provider

**II. Provider Identification**

**A. Corporate Information**

Legal Business Name as Reported to the IRS		Business Supplier Name (DBA)	
Contact Name	Office Telephone	E-mail	
Corporate Address			Date Business Started
City		State	Zip
Office Telephone	Fax Number (if applicable)	E-mail	
Tax Identification Number			

**B. Correspondence Address**

Mailing Address Line 1		Mailing Address Line 2	
City		State	Zip
Office Telephone	Fax Number (if applicable)	E-mail	

**C. Payment/Remittance Address**

Mailing Address Line 1		Mailing Address Line 2	
City		State	Zip
Office Telephone	Fax Number (if applicable)	E-mail	
Payee/Remittance NPI			

**III. Current Practice Locations**

**A. Practice Location Information**

**If there is more than one practice location, copy and complete this section for each. The addresses must be a specific street address. Do not furnish a Post Office Box.**

Practice Location Name		Location NPI	
Practice Location Address Line 1		Practice Location Address Line 2	
City		State	Zip
Office Telephone	Fax Number (if applicable)	E-mail	
What foreign languages are spoken?:			Is this location handicapped accessible? <input type="checkbox"/> Yes <input type="checkbox"/> No

**III. Current Practice Locations (Continued)****B. Location of Patient's Medical Records**

Are all patients' medical records stored at the above address?  Yes – Skip to Section C.  No – Complete this section.

If any patient medical records are stored in a location other than the above address, complete this section with the name and address of the storage location.

Name of Storage Facility/Location

Location Address  
Line 1

Location Address  
Line 2

City

State

Zip

**IV. Primary Practice Information**

Daily Office hours	Sunday <input type="checkbox"/> AM <input type="checkbox"/> PM ____ <input type="checkbox"/> PM ____ <input type="checkbox"/> PM	Monday <input type="checkbox"/> AM <input type="checkbox"/> PM ____ <input type="checkbox"/> PM ____ <input type="checkbox"/> PM	Tuesday <input type="checkbox"/> AM <input type="checkbox"/> PM ____ <input type="checkbox"/> PM ____ <input type="checkbox"/> PM	Holidays Your Office Closes
<b>Wednesday</b> <input type="checkbox"/> AM <input type="checkbox"/> PM ____ <input type="checkbox"/> PM ____ <input type="checkbox"/> PM	<b>Thursday</b> <input type="checkbox"/> AM <input type="checkbox"/> PM ____ <input type="checkbox"/> PM ____ <input type="checkbox"/> PM	<b>Friday</b> <input type="checkbox"/> AM <input type="checkbox"/> PM ____ <input type="checkbox"/> PM ____ <input type="checkbox"/> PM	<b>Saturday</b> <input type="checkbox"/> AM <input type="checkbox"/> PM ____ <input type="checkbox"/> PM ____ <input type="checkbox"/> PM	<input type="checkbox"/> New Year's Day <input type="checkbox"/> Good Friday <input type="checkbox"/> Memorial Day <input type="checkbox"/> Independence Day <input type="checkbox"/> Labor Day <input type="checkbox"/> Thanksgiving <input type="checkbox"/> Christmas Day <input type="checkbox"/> Other

**V. License Information**

Is the agency licensed by the state of Alabama?  Yes  No

State Business  
License number

Original Date  
of License

License  
Renewal Date

County Business  
License number

Original Date  
of License

License  
Renewal Date

City Business  
License number

Original Date  
of License

License  
Renewal Date

**VI. Ownership Information**

Is your organization a subsidiary company or joint venture?  Yes – Complete this section  No – Skip to Section A. – Individual Information

Parent Company or  
Joint Venture Legal Name

Date Business  
Started

Employer ID  
Number

NPI Number

Business Address  
Line 1

Business Address  
Line 2

City

State

Zip

Office  
Telephone

Fax  
Number

E-mail

**Ownership:** Please check all that apply to partners and/or stockholders with more than 10 percent interest.

- |                                  |                                      |   |                                     |
|----------------------------------|--------------------------------------|---|-------------------------------------|
| <input type="checkbox"/> City    | <input type="checkbox"/> Hospital    | <input type="checkbox"/> Sole Ownership | <input type="checkbox"/> For-Profit |
| <input type="checkbox"/> County  | <input type="checkbox"/> Association | <input type="checkbox"/> Corporation    | <input type="checkbox"/> Non-Profit |
| <input type="checkbox"/> State   | <input type="checkbox"/> Foundation  | <input type="checkbox"/> Partnership    |                                     |
| <input type="checkbox"/> Federal | <input type="checkbox"/> Church      | <input type="checkbox"/> Other          |                                     |

**IMPORTANT: For each owner, copy this page and complete Sections A through C below:**

**V. Ownership Information** *(Continued)*

**A. Practice Location Information**

Name <i>(First, Middle, Last, Jr., Sr., M.D., D.O., etc.)</i>		Date of Birth
Country of Birth	Social Security Number	UPIN/NPI Number

**B. Other Organizations Ownership Information**

Do you have ownership in other organizations that bill Blue Cross and Blue Shield of Alabama for services?  Yes – Complete this section  No – Go to Section C

Legal Business Name	Employer ID Number
Blue Cross and Blue Shield of Alabama Plan	Blue Cross and Blue Shield of Alabama Provider Number
	UPIN/NPI Number

**C. Program Exclusions**

Have you ever been excluded from:  Blue Shield  None **If so, indicate why?**

Period of Exclusion	Date of Reinstatement <i>(Attach a copy of reinstatement letter)</i>
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**VII. Billing Information**

Will you be using a billing agency?  YES – Attach a copy of the signed contractual agreement with your billing agency and complete the remainder of this section.  
 No – Skip to Section VIII.

Name of Billing Agency	Employer ID Number	Contact Person
Business Address Line 1	Business Address Line 2	
City	State	Zip
Office Telephone	Fax Number	E-mail

**VIII. Malpractice Information**

Name of Professional Liability Carrier	Professional Liability Insurance Aggregate \$
Length of Time with Current Carrier	Professional Liability Insurance Per Case \$

**IX. E-Practice Management Information**

*e-Practice Management is an electronic information network established and maintained by Blue Cross and Blue Shield of Alabama*

Do you participate in the e-Practice Management Network?  Yes  No **If yes, what portion?**  Patient Accounts (Eligibility and Benefits)  Claims Processing

**X. DME Applicants Only**

Please indicate the equipment categories you will offer.

- |   |   |
|---|---|
| <input type="checkbox"/> General DME-Canes, Crutches, Walkers, Commodes, etc.   | <input type="checkbox"/> Nerve Stimulators, Osteogenesis Stimulators, Muscle Stimulator |
| <input type="checkbox"/> Decubitus Care Equipment   | <input type="checkbox"/> Infusion Pumps and Supplies                                    |
| <input type="checkbox"/> Hospital Beds and Accessories  | <input type="checkbox"/> Traction Equipment, Trapeze                                    |
| <input type="checkbox"/> Oxygen and Respiratory-Ventilators, IPPB, Humidifiers, Nebulizers, Compressors, Suction Pump | <input type="checkbox"/> Wheelchairs and Accessories                                    |
| <input type="checkbox"/> CPAP, BIPAP  | <input type="checkbox"/> Augmentative Communication Devices                             |
| <input type="checkbox"/> Monitoring Equipment-Glucose Monitors, Apnea Monitors  | <input type="checkbox"/> Passive Motion Devices   |
| <input type="checkbox"/> Patient Lifts  | <input type="checkbox"/> Orthotics  |
| <input type="checkbox"/> Pneumatic Compressors and Appliances   | <input type="checkbox"/> Prosthetics  |
| <input type="checkbox"/> Ultraviolet Light, Phototherapy  | <input type="checkbox"/> Diabetic Supplies  |
|   | <input type="checkbox"/> Other  |

Do you maintain copies of contracts you have with third parties?  Yes  No

Do you maintain or offer additional warranties on any items outside of the manufacturer's warranty?  Yes  No

If yes, list companies:

Do you do repairs on your equipment?  Yes  No

Do you contract the repair on our equipment?  Yes  No If yes, list companies:

How are your customer complaints handled?

Do you provide life sustaining respiratory equipment?  Yes – If yes, do you provide 24 hour, 7 days a week emergency service?  Yes  No  
 No

Is your business address the same as your residence?  Yes  No

**XI. Hospice Applicants Only**

Are all professional staff members individually licensed, certified or registered to provide the services which they may be called on to render?

Yes  No – Attach explanation.

Does your agency service all counties in Alabama?  Yes  No

If no, list the counties served:

## XII. Required Information

### Before mailing, you must include the following:

- A copy of your professional liability certificate of insurance from insurance company (Domestic carrier Required)
- A completed W-9 form
- A copy of an IRS letter identifying your tax name and number or a copy of your Federal Deposit Coupon, unless tax exempt
- A copy of all your business licenses and/or zoning permits
- A copy of the Medicare approval letter
- A copy of your State Home Medical Equipment License (DME only)
- Alabama Department of Health Certificate (Hospice only)
- Oxygen certificate – Required for rendering oxygen services (DME only)
- Surety Bond (DME only)
- Network Interest Form – *Check all boxes that apply.*

### Additional – For Ambulance Suppliers Only

- A copy of your Alabama State Board of Health License (*Company*)
- A copy of your State of Alabama Department of Public Health Certificate (*Pharmacy, Fluid and Drugs*)

### Additional – For Prosthetics and Orthotics

- AIA State Board Certificate of Prosthetic and Orthotics (*for fitter*)
- AIA State Board Certificate of Orthotics as Prosthetics and Pedorthics (*for facility and fitter*)

## XIII. Question & Answer

**IMPORTANT: If any of the following questions are answered “Yes,” please provide an explanation for each answer. If any questions do not apply to you, please answer “No”. Failure to check an answer or provide explanations for “Yes” responses may result in delay of application processing. All questions must be answered.**

### License Information

1. Has your organization ever been disciplined, reprimanded, or fined by any state board of medical examiners, professional conduct board, state or federal agency that disciplines organizations?  Yes  No
2. Has your license ever been denied, limited, suspended, revoked, or subject to probation or any conditions or limitations in any state?  Yes  No
3. Has your organization ever been disciplined, suspended, sanctioned, or otherwise restricted from participating in any private, federal or state health plan program (for example, Medicare, Medicaid, professional society or managed care organization) or is any such action pending?  Yes  No
4. Has your organization ever been the subject of any investigation by any private, federal, or state health program or is any such action pending?  Yes  No

### Insurance Information

1. Has your professional liability insurance coverage ever been terminated or modified by action of any insurance company?  Yes  No
2. Has your organization ever been denied professional liability insurance coverage or rated in a higher-than average risk class for your specialty?  Yes  No
3. Have any professional liability suits, actions, or claims alleging malpractice ever been filed against your organization?  Yes  No
4. Are any professional liability suits, actions or claims currently pending against your organization?  Yes  No
5. Have any judgments ever been made against your organization in professional liability cases or claims, or have you ever entered into any settlements?  Yes  No
6. To your knowledge, has information pertaining to you or your organization ever been reported to the National Practitioner Data Bank?  Yes  No
7. Is your organization currently uninsured for professional liability staff (malpractice insurance) coverage?  Yes  No

Explanation:







**REQUEST FOR TAXPAYER  
IDENTIFICATION NUMBER  
SUBSTITUTE FORM W-9**

**This form should be filled out completely. Please print.**

**Part 1: Tax Status**

<b>Name</b> as it appears on Internal Revenue Service (IRS) Records <i>(Required)</i>			
Employer Identification Number	(or)	Social Security Number	Effective Date
<b>If you are a Sole Proprietor or Single-owner LLC</b>			
Personal name of owner of business <i>(Required)</i>			
DBA (doing business as) if different from above <i>(Optional)</i>			

**Part 2: Exemption**

<b>If exempt from form 1099 reporting, you must include a copy of your IRS exemption letter.</b>
<ol style="list-style-type: none"> <li>1. Tax Exempt Entity under 501(a) (includes 501(c) (3)), or IRA;</li> <li>2. The United States or any of its agencies or instrumentalities;</li> <li>3. A state, the District of Columbia, a possession of the United States, or any of their political subdivisions;</li> <li>4. A foreign government, or any of its political subdivisions.</li> </ol>

**Part 3: Certification**

<b>Under penalties of perjury, I certify that:</b>			
<ol style="list-style-type: none"> <li>1. The number shown on this form is my correct taxpayer identification number, and</li> <li>2. I am not subject to backup withholding because:             <ol style="list-style-type: none"> <li>a) I am exempt from backup withholdings, or</li> <li>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</li> <li>c) the IRS has notified me that I am no longer subject to backup withholdings, and</li> </ol> </li> <li>3. I am a U.S. person (including a U.S. resident alien).</li> <li>4. I am exempt from FATCA reporting</li> </ol>			
<b>Name of person completing this form</b>			
<b>Signature</b>			<b>Date</b>
Telephone	Fax	E-mail <i>(optional)</i>	
<b>Tax Address</b>			
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.