BlueCross BlueShield of Alabama

ANCILLARY NETWORK APPLICATION

450 Riverchase Parkway East • Post Office Box 362142
Birmingham, Alabama 35236-2142

An Independent Licensee of the Blue Cross and Blue Shield Association

BlueCross BlueShield of Alabama

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ANCILLARY NETWORK APPLICATION
HELPFUL HINTS

The purpose of collecting this information is to determine the eligibility of individuals and organizations to enroll in the Ancillary Network programs as providers/suppliers of goods and services to Blue Cross and Blue Shield of Alabama members and to assist in the administration of the Blue Cross and Blue Shield of Alabama Networks. Without this information, the ability to make payments will be delayed or denied.

Please be sure to **PRINT** or **TYPE** all information so it is legible. Do not use pencil. Failure to provide all requested information might cause delay in the enrollment process. We strongly suggest that the applicant keep a photocopy of the completed application and supporting documents.

Section I. General Application Information – This section is to identify the reason for submitting this application.

- ☐ **Initial Enrollment for Preferred or Participating Status** – Check this box if you are requesting to be in our Blue Cross and Blue Shield of Alabama Network.
- ☐ **Blue Shield Provider Number** – Check this box if you are requesting a Blue Shield Provider Number only and are not requesting to be in our Participating Network.
- ☐ **Change of Information** – Check this box if you are submitting any change of information.
- ☐ **Change of Ownership/Tax ID** – Check this box if there has been a change of ownership or Tax ID change. You must complete the entire application.

Also remember:

- ☐ ***Indicate which type of supplier/provider specification you are requesting. If you are requesting a Blue Shield Provider number only, check the box that identifies the type of services you provide.***
- ☐ Provider the supplier's Tax Identification Number. This is the number the supplier uses to report tax information to the IRS. Please provide a copy of an IRS letter identifying your tax name and number **or** a copy of your Federal Deposit Coupon, unless tax exempt.
- ☐ If you are tax exempted, attach a copy of Exemption Certification from the IRS.
- ☐ Be sure to indicate if you already have a Blue Cross and Blue Shield of Alabama Plan code and provider number.

Section II. Provider Information – This section is to be completed with information related to the supplier submitting the application.

This includes:

- ☐ Provider Information
- ☐ Correspondence Address
- ☐ Payment/Remittance Address

Section III. Current Practice Locations – Complete this section including practice location information, location of patients' medical records and any comments that may explain any unusual circumstances concerning the provider's practice location(s).

- ☐ 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.
- ☐ You will receive a specific provider number for each identified location.

Section IV. License Information – Depending on your location, provide all applicable license information.

Section V. Ownership Information – This section is to be completed with information about any individual or organization that has a 5 percent or greater ownership in the supplier identified in Section II. A.

- ☐ If your organization is a subsidiary company or joint venture, complete the first section and the following sections A, B and C where applicable. If you are not a subsidiary company or joint venture, then complete sections A, B and C of this section.
- ☐ For each owner, copy the page and complete Sections A through C.

ANCILLARY NETWORK APPLICATION

HELPFUL HINTS (CONTINUED)

Section VI. Business Hours – This section is to be completed to communicate the supplier's business hours and holidays.

Section VII. Billing Information – This section is to be completed for the purpose of effective monitoring of agents that prepare and/or submit claims to bill Blue Cross and Blue Shield of Alabama. If the supplier uses a billing agency, you must attach a copy of the signed contractual agreement with your billing agency. Complete all sections.

Section VIII. Malpractice Information – All suppliers must have a minimum of $1,000,000 aggregate amount and $1,000,000 per case.

Section IX. e-Practice Management Information – After reading the information at **https://www.bcbsal.org/providers/edi/index.cfm** call the EDI Department with any questions concerning electronic billing at 205-220-6899.

Section X. DME Applicants Only – This section is to be completed by DME suppliers only. Regarding the last question in this section, Blue Cross and Blue Shield of Alabama requires a supplier to maintain a physical facility on an appropriate site within the State of Alabama. A person's place of residence is not considered an adequate physical facility.

Section XI. Home Health and Hospice Applicants Only – This section is to be completed by home health and hospice suppliers only.

Section XII. Home Health Applicants Only – This section is to be completed by home health suppliers only.

Section XIII. Hospice Applicants Only – This section is to be completed by hospice applicants only. To be a Participating Hospice provider, the agency must have an Alabama Department of Health Certificate.

Section XIV. Required Information – To insure timely processing you must send in all documentation with your application.

Section XV. Provider Certification Section – Read this section very carefully and if the supplier agrees to all the terms and conditions set forth in this section, then you must have an authorized official of the agency sign and date this section. An authorized official must be a general partner, board member, chief financial officer, chief executive officer, president, direct owner, or must hold a position of similar status and authority within the organization.

Applications should be mailed to the address below. Applications may be faxed to 205-220-9545.

Blue Cross and Blue Shield of Alabama

ATTN: Provider Credentialing

Post Office Box 362142

Birmingham, Alabama 35236-9850

BlueCross BlueShield of Alabama

An Independent Licensee of the Blue Cross and Blue Shield Association

ANCILLARY NETWORK APPLICATION

Instructions

- *Please PRINT or TYPE a response for each question.*
- *Please attach the copies of the documents and any additional information requested.*
- *Please indicate N/A if a question is not applicable.*
- *Please understand that these questions are asked of all participants*
- *Your responses will be used by the Credentialing Committee and will remain confidential.*

Upon completion, please return in the enclosed envelope.

☐ Add New Provider	☐ Update existing provider information	☐ Add a location	☐ Update existing location	Effective Date of Change	

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 Home Health Provider ☐ Participating Hospice Provider ☐ Participating Ambulance Provider

Tax Identification Number: **Tax Exempt:** ☐ Yes – Attach a copy of Exemption Certification from the IRS. ☐ No

II. Provider Identification

A. Provider Information

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

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?** ☐ Yes ☐ 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

C. Comments

Explain any unique or unusual circumstances concerning the provider's practice location(s) or the method by which the provider renders healthcare services.

If there is more than one practice location, copy and complete this section for each.

IV. 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

V. 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.*

☐ City	☐ Hospital	☐ Sole Ownership	☐ For Profit
☐ County	☐ Association	☐ Corporation	☐ Non-Profit
☐ State	☐ Foundation	☐ Partnership	
☐ Federal	☐ Church	☐ Other _____	

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

V. Ownership Information *(Continued)*

A. Practice Location Information

Name *(First, Middle, Last, Jr., Sr., M.D., D.O., etc.)*		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 *(Attach a copy of reinstatement letter)*

VI. Business Hours

Business Hours	Sunday	Monday	Tuesday
	_____ ☐ AM _____ ☐ PM _____ ☐ AM _____ ☐ PM	_____ ☐ AM _____ ☐ PM _____ ☐ AM _____ ☐ PM	_____ ☐ AM _____ ☐ PM _____ ☐ AM _____ ☐ PM

Wednesday	Thursday	Friday	Saturday
_____ ☐ AM _____ ☐ PM _____ ☐ AM _____ ☐ PM	_____ ☐ AM _____ ☐ PM _____ ☐ AM _____ ☐ PM	_____ ☐ AM _____ ☐ PM _____ ☐ AM _____ ☐ PM	_____ ☐ AM _____ ☐ PM _____ ☐ AM _____ ☐ PM

Holidays Your Office Closes:

☐ New Year's Day	☐ Good Friday	☐ Memorial Day	☐ Independence Day
☐ Labor Day	☐ Thanksgiving	☐ Christmas Day	☐ Other _____

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

Please indicate the equipment categories you will offer.

- ☐ General DME-Canes, Crutches, Walkers, Commodes, etc.
- ☐ Decubitus Care Equipment
- ☐ Hospital Beds and Accessories
- ☐ Oxygen and Respiratory-Ventilators, IPPB, Humidifiers, Nebulizers, Compressors, Suction Pump
- ☐ CPAP, BIPAP
- ☐ Monitoring Equipment-Glucose Monitors, Apnea Monitors
- ☐ Patient Lifts
- ☐ Pneumatic Compressors and Appliances
- ☐ Ultraviolet Light, Phototherapy
- ☐ Nerve Stimulators, Osteogenesis Stimulators, Muscle Stimulator
- ☐ Infusion Pumps and Supplies
- ☐ Traction Equipment, Trapeze
- ☐ Wheelchairs and Accessories
- ☐ Augmentative Communication Devices
- ☐ Passive Motion Devices
- ☐ Orthotics
- ☐ Prosthetics
- ☐ Diabetic Supplies
- ☐ 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. Home Health and 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. Home Health Applicants Only

Professional Services

Please check all professional services provided directly by this home care agency. List subcontracted services below:

- ☐ Medical Social Services
- ☐ Occupational Therapy
- ☐ Respiratory Therapy
- ☐ Speech Therapy
- ☐ Skilled Nursing Services
- ☐ Diet or Nutritional Therapy
- ☐ Home Phototherapy
- ☐ Pediatric Nursing
- ☐ Physical Therapy
- ☐ Home Health Aid Services
- ☐ Home I.V. Therapy
- ☐ Other _____
- ☐ Subcontracted Services: _____

Accreditation

Is this agency accredited? ☐ Yes ☐ No ☐ Pending	Date of Accreditation	Last Date Surveyed

- ☐ Joint Commission on Accreditation of Healthcare Organizations (JCAHO)
- ☐ Community Health Accreditation Program, Inc. (CHAPS)
- ☐ Accreditation Commission for Home Health Care, Inc. (ACHC)

XIII. 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
- ☐ Alabama Department of Health Certificate (Hospice only)
- ☐ Accreditation certificate (Home Health only)
- ☐ A copy of your State Home Medical Equipment License (DME only)
- ☐ Oxygen certificate – Required for rendering oxygen services (DME only)
- ☐ Surety Bond (DME only)
- ☐ Network Interest Form

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)*

XIV. 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: _____

_____

_____

_____

_____

_____

_____

_____

XV. Provider Certification Section *(Please keep a copy of this application and all attachments for your records.)*

I have read the contents of this application and the information contained herein is true, correct, and complete. I have used reasonable care in determining the truthfulness, correctness and completeness of all information in this application before signing below. If I become aware that any information in this application is not true, correct, or complete, I agree to notify Blue Cross and Blue Shield of Alabama to verify the information contained herein. I agree to notify Blue Cross and Blue Shield of Alabama of any changes in this information within 30 days of the effective date of the change. I understand that a change in the incorporation of my organization or my status as an individual or group biller may require a new application. I am familiar with and agree to abide by the Blue Cross and Blue Shield programs that apply to my provider type. I agree that any existing or future overpayment to me by Blue Cross and Blue Shield may be recouped by Blue Cross and Blue Shield through future payments. I understand that my name and specialty may be listed in directories published by Blue Cross and Blue Shield of Alabama at its discretion but without obligation to do so. I understand that any provider number assigned may be cancelled if no claims activity occurs for a 6-month period. I understand that willful falsification or willful omission of this information could be grounds for termination. I understand that this application alone does not entitle or guarantee participation in any Provider Program offered by Blue Cross and Blue Shield of Alabama. In the event I am selected to participate in any Participating or Preferred Provider Program offered by Blue Cross and Blue Shield of Alabama, this application and all information will be incorporated by reference, and become part of any Provider Agreement. My signature here authorizes verification of the information I have provided.

Printed Name of Provider	Provider's Handwritten Signature	Date Signed

Please furnish the following information regarding a person we may contact in the event of any questions or additional information needs.

Contact Name	Office Telephone	E-mail

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 Post Office Box 362142, Birmingham, AL 35236-2142

BlueCross BlueShield of Alabama

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FACILITY BUSINESS NETWORK INTEREST APPLICATION 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 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 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	Internal Use Only (Effective Date)
	Participating Ground Ambulance	All Kids/Blue Advantage/Commercial Ground	Open	
	Participating Air Ambulance	Air Ambulance/Blue Advantage	Open	
	Participating Ambulatory Surgery Center	Multi-Specialty	Open	
	Preferred Single Specialty Ambulatory Surgery Center	☐ Eye ☐ Gastroentrology ☐ Plastic Surgery	Open	
	Participating Dialysis	Dialysis	Open	
	Preferred Medical Laboratory (PML)	Clinical Labs with CLIA Certification	Open	n/a
	Participating Residential Treatment Facility	Certified by the Alabama Dept. of Mental Health	Open	
	Blue Advantage® – Medicare Advantage Program	☐ ASC ☐ DME ☐ ESRD ☐ Home Health ☐ IDTF ☐ Laboratory ☐ Mental Health ☐ Pharmacy ☐ Portable Image ☐ Rural Health ☐ SNF-Pharmacy Infusion	Open	
	Preferred Home Health Agency	Home Health 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 BCBSAL 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		Internal Use Only	–
DBA		Organizational NPI	
Contact Name		Tax ID Number	–
E-mail	Office Phone	Fax Number	
Location Address			
City	State	Zip	County
Mailing Address			
City	State	Zip	County
Officer 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 Post Office Box 362142, Birmingham, AL 35236-2142

BlueCross BlueShield of Alabama

An Independent Licensee of the Blue Cross and Blue Shield Association

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.

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Electronic Funds Transfer (EFT) Instructions

Electronic funds transfer (EFT) is an easy and efficient way to ensure your Blue Cross and Blue Shield of Alabama payments are deposited directly into your bank account. EFT is secure, confidential and convenient, and there is no charge to you for this service.

In order to participate in EFT, your financial institution must be a participating member of the Automated Clearinghouse Association (ACH). You must contact your financial institution to arrange for the delivery of reassociation information. It is the provider's responsibility to notify Blue Cross of any changes to your banking information. Please allow 10-15 business days for processing. Processing times may vary.

To ensure that your EFT account is set up correctly, use the following instructions when completing your enrollment form.

- ☑ Please use one enrollment form per tax ID number.
- ☑ Include both your individual and organizational National Provider Identifier (NPI) numbers on the form.
- ☑ Include a copy of a pre-printed voided check or bank authorization letter. Deposit slips and starter checks are not acceptable.
- ☑ The form must be signed certifying the information as accurate to the best of your knowledge.
- ☑ The EFT Authorization Agreement form can be returned to Blue Cross and Blue Shield of Alabama in one of the following ways:

By Mail:

Blue Cross and Blue Shield of Alabama
Provider Accounting
Attn: EFT Processor
PO BOX 362130
Birmingham, AL 35236-2130

By Fax:

Blue Cross and Blue Shield of Alabama
Provider Accounting
Attn: EFT Processor
205-220-2795

By Email:

ProviderAccountingEFT@bcbsal.org

The EFT Authorization Agreement form is available online through **AlabamaBlue.com/providers**. The "Direct Deposit Registration Online Instructions" will help you complete the agreement correctly.

If you have questions or need additional information, please call Provider Accounting at **205-220-4745**. Leave a message and a representative will get back with you.

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ELECTRONIC FUNDS TRANSFER (EFT) AUTHORIZATION AGREEMENT

Provider Name	**Internal Use Only:**
Provider Address	
City	**State** / **Zip**
Provider Federal Tax Identification Number (TIN) (9 Digits)	
National Provider Identifier (NPI) (10 Digits) (Billing/Payee)	**National Provider Identifier (NPI)** (10 Digits) (Individual)

This authority is to remain in full force and effect until Blue Cross and Blue Shield of Alabama has received written notification from me of its termination in such time and in such manner as to afford Blue Cross and Blue Shield of Alabama and DEPOSITORY a reasonable opportunity to act on said notice of termination. Blue Cross and Blue Shield of Alabama reserves the right to return or adjust any errors in accordance with applicable National Automated Clearinghouse Association Operating Rules.

Provider Contact Name	**Title**	
Telephone Number	**Email Address**	**Fax Number**

I (we) hereby authorize Blue Cross and Blue Shield of Alabama to initiate credit entries (deposits) to my (our) checking account at the depository named below (hereinafter called Depository), and to credit the same to such account.

Financial Institution Name		
Financial Institution Routing Number (9 Digits)	**Type of Account at Financial Institution** ☐ Checking ☐ Savings	**Provider's Account Number with Financial Institution**

Reason for Submission:

☐ **Initial Setup** ☐ **Edit or Change to Current EFT Account** ☐ **Add or Drop Provider** ☐ **Cancel EFT**

(Optional - Attach an original or copy of a voided check or bank letter)

I certify this information is complete and correct to the best of my knowledge.	**Authorized Signature**	**Date**

* Initial updates or changes will require a two week set-up period with the bank. You will continue to receive checks during this period.

Please return this form to:

Email
ProviderAccountingEFT@bcbsal.org

If you have questions, please contact us at:
205-220-4745

Fax
Blue Cross and Blue Shield of Alabama
Provider Accounting
Attn: EFT Processor
205-220-2795

Mail
Blue Cross and Blue Shield of Alabama
Provider Accounting
Attn: EFT Processor
PO BOX 362130
Birmingham, AL 35236-2130