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.*

| ☐ Add New Provider | ☐ Update Existing Provider Information | ☐ Add a Location | ☐ 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?** ☐ 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 |

## IV. Primary Practice Information

| Daily Office hours | *Sunday* ☐ AM ☐ PM<br>_____ ☐ PM _____ ☐ PM | *Monday* ☐ AM ☐ PM<br>_____ ☐ PM _____ ☐ PM | *Tuesday* ☐ AM ☐ PM<br>_____ ☐ PM _____ ☐ PM | **Holidays Your Office Closes** |
|---|---|---|---|---|
| *Wednesday* ☐ AM ☐ PM<br>_____ ☐ PM _____ ☐ PM | *Thursday* ☐ AM ☐ PM<br>_____ ☐ PM _____ ☐ PM | *Friday* ☐ AM ☐ PM<br>_____ ☐ PM _____ ☐ PM | *Saturday* ☐ AM ☐ PM<br>_____ ☐ PM _____ ☐ PM | ☐ New Year's Day ☐ Good Friday ☐ Memorial Day<br>☐ Independence Day ☐ Labor Day ☐ Thanksgiving<br>☐ Christmas Day ☐ 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.*

| | | | |
|---|---|---|---|
| ☐ 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)* |

## 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.*

- ☐ 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:**

**If you are an out of state provider (location address outside the State of Alabama), are you contracted through CareSourcing with the Blue Cross and Blue Shield Association?** ☐ Yes ☐ No **If yes, please attach a copy of your CareSourcing Agreement.**

**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.*
- ☐ Accreditation certificate

**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:

## XIV. 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 CEO | CEO'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:

| Phone Number: | Fax Number: | Email: |
|---|---|---|

## 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<br>Post Office Box 362142, Birmingham, AL 35236-2142 |
|---|---|---|---|

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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**. 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** | Multi-Specialty | Open |
| | **Preferred Single Specialty Ambulatory Surgery Center** | Dermatology Eye Gastroenterology Plastic Surgery | Open |
| | **Participating Dialysis** | Dialysis | Open |
| | **Preferred Medical Laboratory (PML)** | Clinical Labs with CLIA Certification | Open |
| | **Participating Residential Treatment Facility** | Certified by the Alabama Department 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 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 |
|---|---|---|---|

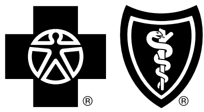
| Signature | Title | Date |
|---|---|---|

## 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

Blue Advantage® is a Medicare-approved PPO Plan provided by Blue Cross and Blue Shield of Alabama, an independent licensee of the Blue Cross and Blue Shield Association.



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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.