Application to Add New Provider Location

Practitioner Information

First Name* | Middle Name | Last Name* | Suffix

Preferred Name | Gender | Social Security Number*

If your professional license has ever been issued under a name other than the name listed above (e.g. maiden name, alias, nicknames) please indicate below:

First Name | Middle Name | Last Name | Suffix

Birth Date (mm/dd/yyyy)*

Did you complete your medical school or medical training in a foreign country?* ☐ Yes ☐ No

If Yes, please provide your ECFMG Certificate Number

Practitioner E-Mail Address

Degree Type*

☐ AA	☐ Clinic	☐ CCC SLP	☐ CNM	☐ CNS
☐ CRNA	☐ CSA	☐ CST	☐ CSW	☐ DC
☐ DDS	☐ DDS MD	☐ DMD	☐ DMD MD	☐ DMIN
☐ DO	☐ DPM	☐ EDD	☐ ED S	☐ LCSW
☐ LD	☐ LMFT	☐ LP	☐ LPC	☐ LPN
☐ MA	☐ MD	☐ MD DDS	☐ MD DMD	☐ MD PHD
☐ MED	☐ MS	☐ NP	☐ OD	☐ OTR
☐ PA	☐ PHD	☐ PHD MD	☐ PSY D	☐ RD
☐ RN	☐ RPT	☐ Other: _____		

Are you fluent in any languages other than English?

☐ Italian	☐ Arabic	☐ Chinese	☐ Japanese	Other language not listed: _____
			☐ Spanish	☐ French ☐ German

US Citizen* ☐ Yes ☐ No - If No, Alien Registration Number

Country of Birth*

Legal Right to Work in U.S.?* ☐ Yes ☐ No

County of Birth* | State of Birth

Do you have physician coverage for your patients 24 hours per day, seven days per week?* ☐ Yes ☐ No

NPI | NPI Effective Date

* Indicates Required Field

Application to Add New Provider Location

Practice Information

Legal Practice Name*

Tax ID*

Tax ID Start Date

DBA

Office Effective Date*

If this location is a hospital, please specify name

Street Address*

Suite/Building

City*

State*

ZIP*

County*

Do you accept Medicare patients? * ☐ Yes ☐ No AL Medicare # AL Medicaid #

Office Telephone Number* ( )

Appointment Telephone Number* ( )

Office Fax Number ( )

Is a Telephone Device for the Deaf (TDD) Available?* ☐ No ☐ Yes – TDD Telephone Number (_____) _____

Office E-Mail Address

Office Manager

Title First Name Last Name Suffix

Primary Practicing Specialty*

Secondary Practicing Specialty

Languages spoken by staff in addition to English: ☐ Spanish ☐ French ☐ German ☐ Italian ☐ Arabic ☐ Chinese ☐ Japanese ☐ Other: _____

Handicap Access? * ☐ Yes ☐ No

Are you accepting new patients? * ☐ Yes ☐ No ☐ Not Applicable

Office Practice Type* ☐ Individual ☐ Group

Is this location an Urgicenter, After Hours or Urgicare Clinic?* ☐ Yes ☐ No

Physician Type
☐ Primary Care Physician
☐ Specialist

Will you be providing Emergency Room Services? ☐ Yes ☐ No

Are there age limitations on your patients?* ☐ No ☐ Yes – Please specify from _____ years to _____ years

CLIA Certificate Number

CLIA Expiration Date (mm/dd/yyyy)

CLIA Waiver ☐ Yes ☐ No

• Indicates Required Field

Application to Add New Provider Location

Practice Information

Do you perform surgery in your office?* ☐ Yes ☐ No

Is your location a residence?* ☐ Yes ☐ No

If residence, please provide

Business License Number _____ Zoning Permit Number _____

Office Hours*

	Monday		Tuesday		Wednesday	
	From	To	From	To	From	To

	Thursday		Friday		Saturday		Sunday	
	From	To	From	To	From	To	From	To

Holidays your office closes*

☐ New Year's Day ☐ Good Friday ☐ Memorial Day ☐ Independence Day ☐ Labor Day

☐ Thanksgiving ☐ Christmas Day ☐ Other, please specify: _____

Correspondence Address ☐ Is this address the same as the office practice address?

Street Address _____ Suite/Building _____

City _____ State _____ ZIP _____

Telephone Number ( ) Fax Number ( )

Billing Address ☐ Is this address the same as the office practice address?

Is this a billing agency? * ☐ No ☐ Yes – If yes, Name: _____

Billing NPI _____ Billing NPI Effective Date _____

Street Address _____ Suite/Building _____

City _____ State _____ ZIP* _____

Office Telephone Number* ( ) Office Fax Number ( )

Office E-Mail Address: _____

• Indicates Required Field

Application to Add New Provider Location

Covering Physicians

Your covering physicians should agree to the same fees and follow the same administrative procedures.

First Name* | Middle Name | Last Name* | Suffix

NPI | Telephone Number*

Specialty*

First Name* | Middle Name | Last Name* | Suffix

NPI | Telephone Number*

Specialty*

First Name* | Middle Name | Last Name* | Suffix

NPI | Telephone Number*

Specialty*

First Name* | Middle Name | Last Name* | Suffix

NPI | Telephone Number*

Specialty*

Make additional copies of this page as necessary

*Indicates Required Field

Application to Add New Provider Location

State Medical License

State Medical License

In the State of *

☐ I am in the process of applying for a Medical License

☐ I hold a valid Medical License

License/Certificate #*

Issue Date (mm/dd/yyyy)*

Expiration Date (mm/dd/yyyy)*

Does this license/certification level require supervision?* ☐ Yes ☐ No

Board Description*

(Additional) State Medical License

In the State of *

☐ I am in the process of applying for a Medical License

☐ I hold a valid Medical License

License/Certificate #*

Issue Date (mm/dd/yyyy)*

Expiration Date (mm/dd/yyyy)*

Does this license/certification level require supervision?* ☐ Yes ☐ No

Board Description*

(Additional) State Medical License

In the State of *

☐ I am in the process of applying for a Medical License

☐ I hold a valid Medical License

License/Certificate #*

Issue Date (mm/dd/yyyy)*

Expiration Date (mm/dd/yyyy)*

Does this license/certification level require supervision?* ☐ Yes ☐ No

Board Description*

• Indicates Required Field

Application to Add New Provider Location

Current Hospital Admitting Privileges

Hospital Admitting Privileges - Please list your current hospital admitting privileges

Hospital Name* NPI

Street Address Suite/Building

City State ZIP

Telephone Number* Fax Number Medical Staff Department*

( ) ( )

What is your Staff Category?*

☐ Active ☐ Affiliate ☐ Applied/Pending ☐ Associate ☐ Consulting

☐ Courtesy ☐ None ☐ Provisional ☐ Temporary

If Staff Category is *Applied/Pending*, list Application Date (mm/dd/yyyy)

Effective Date* Re-appointment Date*

Month Year Month Year

Admitting Privileges *

☐ My specialty does not admit patients

If your specialty admits patients, please complete the following information:

Percent of patients you admit to this hospital %

☐ I admit my own patients to the hospital

☐ Another practitioner admits on my behalf

If another practitioner admits on your behalf, please provide the following information:

First Name Middle Last Name Suffix

Telephone Number Specialty

( )

Please explain why another practitioner admits on your behalf:

Make additional copies of this page as necessary

* Indicates Required Field

Application to Add New Provider Location

Provider Authorization

I hereby give permission to the selected entities and/or its designee to request information regarding my professional credentials and qualifications from educational facilities, the chief(s) of the clinical department(s) of the hospital(s) in which I currently have or formerly have had medical staff membership and/or clinical privileges, professional certification boards, state regulatory and licensing departments, professional liability insurance carriers, other professional monitoring entities, and present and past employers.

The information requested may include otherwise privileged or confidential material relative to my professional qualifications, credentials, claims history, clinical and/or professional competence, character, ethics, or any other matter having bearing on the credentialing procedure. I release and agree to hold harmless the selected entities and its affiliates to whom this information is given and their representatives, employees and agents from any and all liability for any damages, costs, and expenses which may result from the gathering or use of such information, as long as such release or use of information is done in good faith and without malice.

I hereby authorize the educational facilities, the chief(s) of the clinical department(s) of the hospital(s) in which I currently have or formerly have had staff privileges, professional certification boards, state regulatory and licensing departments, professional liability carriers, other professional monitoring entities and present and past employers to submit information requested by the selected entities including otherwise privileged or confidential material relative to my professional qualifications, credentials, past and present malpractice coverage, claims and suit information, clinical and/or professional competence, character, ethics, or any other matter having bearing on the credentialing procedure. I hereby further release and agree to hold harmless all such entities, their representatives, employees and agents from any and all liability for any damages which may result from providing this information, as long as such release or use of this information is done in good faith and without malice. I further agree the burden shall be upon me to prove such release was done in bad faith and with malice by a preponderance of evidence.

I agree that a photocopy or facsimile of this document with my signature may be accepted by any person or entity from which such information is sought with the same authority as the original and I specifically waive written notice from any such entities or individuals who may provide information based upon this authorized request.

I represent that the information provided in or attached to this Application and the most current information provided to the selected entities is accurate and complete. I understand that a condition of this Application is that any misrepresentation, misstatement or omission from this Application, whether intentional or not, is cause for automatic and immediate rejection of this Application by the selected entities and may result in denial of my application or termination of my participation in the selected entities. I further understand that any misrepresentation, misstatement or omission from this Application, if discovered after participation has been awarded to me, may lead to immediate suspension or termination of those privileges. I agree to use my best efforts to inform the selected entities in writing within 30 days if there is any change in the information provided or the answers to questions on the Application as a result to developments subsequent to my signing this Application.

I warrant that I have the authority to sign this Application, on my behalf, and on behalf of any entity or organization for which I am signing in a representative capacity. I agree that submission of this Application does not constitute approval or acceptance of this application or me by the entity as a participating provider. I further agree that this application may only qualify as a "pre-application" under the rules of the entity.

I understand that if my application is rejected for reasons relating to my professional conduct or clinical competence, the selected entities may be required to report the rejection to the appropriate state licensing board and/or National Practitioner Data Bank.

This attestation statement must be signed no more than 180 days prior to the credentialing decision. If the credentialing review and decision takes place more than 180 days after the signature below, provider must re-sign and date this application page attesting that all application page attesting that all application information remains current, complete and correct.

☐ I have reviewed and **AGREE** to this attestation statement

☐ I have reviewed and **DO NOT AGREE** to this attestation statement

I UNDERSTAND THAT THIS APPLICATION DOES NOT ENTITLE ME TO PARTICIPATION IN ANY HOSPITAL, HEALTH CARE ENTITY, OR HEALTH PLAN.

The undersigned, being hereby warned that intentional or unintentional false statements and the like so made may jeopardize the validity of the application, declares that he/she is properly authorized to execute this application; and that all statements made of his/her own knowledge are true; and that all statements made on information and belief are believed to be true.

Signature	**Signatory's Name**	**Date:**

Application to Add New Provider Location

Contact Information

Please verify that the contact information for this application is current. Any questions about this application will be directed to this person. All information is required.

Contact First Name*

Contact Last Name*

Contact Telephone Number*

Contact E-Mail Address*

BlueCross BlueShield of Alabama

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PRACTITIONER 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. Par Status follows the provider, and adding a location is for administrative and claims processing purposes only. Providers being recredentialed must enroll and attest to the correctness of their information in CAQH.

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
	Preferred Medical Doctor (PMD) Program	MDs and DOs (excludes Psychiatry)	Open
	Preferred Optometry Network	Optometrist	Open
	Preferred Podiatry Network	Podiatrist	Open
	Participating Chiropractor Network	Chiropractors	Open
	Preferred Therapy Network *(Choose an option to the right.)*	☐ Audiologist ☐ Occupational Therapist ☐ Physical Therapist ☐ Speech and Language Pathologist	Open
	Preferred Physician Laboratory (PPL)	Physician in-house labs with CLIA Certification	Open
	Physician Extender Networks – Licensed *(Choose an option to the right.)*	☐ Anesthesia Assistant ☐ Nurse Midwife ☐ Nurse Practitioner ☐ Certified Registered Nurse Anesthetist ☐ Physician Assistant	Open
	Participating Licensed Registered Dietitian	Dietitian	Open
	ALL Kids Participating – ALL Kids Only *(Choose an option to the right.)*	☐ Ophthalmologist ☐ Opticians ☐ Optometrist	Open
	Preferred Dentist – Statewide Dental Network *(Choose an option to the right.)*	☐ Dentists ☐ Oral Surgeons	Open
	Blue Advantage – Medicare Advantage Program	Medicare Eligible Participating Providers	Open
	Preferred Sleep Medicine Program *(Choose an option to the right.)*	☐ In Home Accredited ☐ In Lab Accredited	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.

Provider Name		Internal Use Only	
Individual NPI *(National Provider Identifier)*		Organizational NPI	
Practice Name		Tax ID Number	
Email	Office Phone	Fax Number	
Office Address			
City	State	Zip	County
Mailing Address			
City	State	Zip	County
Provider Signature			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

Electronic Funds Transfer (EFT) Enrollment

Enrolling in EFT is free to all healthcare providers.

1. **Provider submits bank information**

2. **Support Desk assists enrollment and verifies**

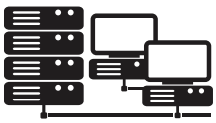
Zelis

3. **Blue Cross and Blue Shield of Alabama enrollment**

4. **Plan sends payment with ACH-CD+TRN**

Provider's Bank

5. **Payment Info**



Provider's System

Providers are required to receive claims payments electronically via an electronic payments automated clearing house (ACH). To make this easier for you, we have enlisted Zelis to enroll our providers for ACH payments using their enrollment platform.

We use Zelis because it is a safe, secure way for your practice to sign up for electronic payments with our plan. You maintain complete control of your secure account and can make changes at any time.

Some benefits of receiving payments electronically are below:

- Reduced administrative costs associated with receiving and depositing paper checks
- Safer and more secure than paper checks, which can get lost in the mail or stolen
- Improve cash flow.
- Payments are received more quickly. Blue Cross deposits electronic payments every Wednesday.

To enroll for EFT, or review or change your EFT banking information, log in to *ProviderAccess* and click on **Direct Deposit/EFT Registration** under Payment & Refund in the main menu.

Questions during EFT enrollment?
Contact Zelis at 1-877-882-0384,
Monday – Friday, 8 a.m. – 7 p.m. Central time.

Questions post-EFT enrollment?
Contact Treasury Operations at 205-220-4745 or email provideraccountingeft@bcbsal.org

Zelis is an independent company that provides electronic fund transfer enrollment services to Blue Cross and Blue Shield of Alabama, an independent licensee of the Blue Cross and Blue Shield Association.

BlueCross BlueShield of Alabama

An Independent Licensee of the Blue Cross and Blue Shield Association

PRV20395-2110

BlueCross BlueShield of Alabama

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HOSPITAL DATA FORM

This form is for hospital admitting privileges information only.

Provider Information

Provider Name	National Provider Identifier (NPI)	
Address		
City	State	Zip
Phone	Fax Number	E-mail

I hereby attest that: *(Check one please)* ✓

☐ I do not have any **admitting** privileges because my specialty does not admit patients.	Specialty	
☐ I do not have any privileges because I use a hospitalist.	Hospitalist Name	National Provider Identifier (NPI)
☐ I have **admitting** privileges at:	Primary Hospital	
City	State	Zip

Additional Hospitals to which you have admitting privileges may be listed on page 2.

Date my privileges were initially granted at this hospital: *(mm/dd/yyyy)*

Next reappointment/review date to continue my privileges at this hospital is: *(mm/dd/yyyy)*

My level of admitting privileges at this hospital is: *(check one)* ☐ Full ☐ Temporary ☐ Courtesy ☐ None

☐ Applied/Pending Date Applied: *(mm/dd/yyyy)* Expected date of Decision: *(mm/dd/yyyy)*

My current standing at this hospital is: *(check one)* ☐ Good standing with no issues ☐ Restricted ☐ Probationary

If you have any adverse actions from this hospital, including investigations or pending action, please attach a detailed explanation of the situation.

I also hereby grant permission to this hospital to verify and/or release my information including:

1. The effective date my privileges were initially granted at this hospital
2. The upcoming reappointment/review date for continued privileges at this hospital
3. My current standing at this hospital
4. Any adverse actions upon my privileges, including investigations and pending actions, at this hospital.
5. Any other information that may be pertinent to the evaluation process.

I understand this information will be released to the Credentialing Unit for the purpose of properly evaluating me for participation in the Preferred Care Programs.

Requires original signature of the physician.

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

_____ Physician Signature

_____ 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
Post Office Box 362142, Birmingham, AL 35236-2142

Additional Hospitals to which you have admitting privileges

☐ I have **admitting** privileges at: Hospital

City | State | Zip

Date my privileges were initially granted at this hospital: *(mm/dd/yyyy)*

Next reappointment/review date to continue my privileges at this hospital is: *(mm/dd/yyyy)*

My level of admitting privileges at this hospital is: *(check one)* ☐ Full ☐ Temporary ☐ Courtesy ☐ None
☐ Applied/Pending Date Applied: *(mm/dd/yyyy)* Expected date of Decision: *(mm/dd/yyyy)*

My current standing at this hospital is: *(check one)* ☐ Good standing with no issues ☐ Restricted ☐ Probationary
If you have any adverse actions from this hospital, including investigations or pending action, please attach a detailed explanation of the situation.

☐ I have **admitting** privileges at: Hospital

City | State | Zip

Date my privileges were initially granted at this hospital: *(mm/dd/yyyy)*

Next reappointment/review date to continue my privileges at this hospital is: *(mm/dd/yyyy)*

My level of admitting privileges at this hospital is: *(check one)* ☐ Full ☐ Temporary ☐ Courtesy ☐ None
☐ Applied/Pending Date Applied: *(mm/dd/yyyy)* Expected date of Decision: *(mm/dd/yyyy)*

My current standing at this hospital is: *(check one)* ☐ Good standing with no issues ☐ Restricted ☐ Probationary
If you have any adverse actions from this hospital, including investigations or pending action, please attach a detailed explanation of the situation.

☐ I have **admitting** privileges at: Hospital

City | State | Zip

Date my privileges were initially granted at this hospital: *(mm/dd/yyyy)*

Next reappointment/review date to continue my privileges at this hospital is: *(mm/dd/yyyy)*

My level of admitting privileges at this hospital is: *(check one)* ☐ Full ☐ Temporary ☐ Courtesy ☐ None
☐ Applied/Pending Date Applied: *(mm/dd/yyyy)* Expected date of Decision: *(mm/dd/yyyy)*

My current standing at this hospital is: *(check one)* ☐ Good standing with no issues ☐ Restricted ☐ Probationary
If you have any adverse actions from this hospital, including investigations or pending action, please attach a detailed explanation of the situation.

BlueCross BlueShield of Alabama

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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.

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ORGANIZATIONAL/PAYEE/ BILLING NPI FORM

It is important that Blue Cross has accurate information about your Individual or Organizational NPI. Providers must notify Blue Cross if this information changes. Blue Cross is unable to use NPIs for billing purposes that have not previously been reported. An accurate NPI is required for additional important purposes including remittance payments, Internal Revenue Service (IRS) reporting, directories and publication mailings.

Fill out form completely. Please print.

Please indicate your Organizational/Payee/Billing NPI information below.

Organizational NPI (National Provider Identifier)		Effective Date
Name		
Address		
City	State	Zip
Office Telephone	Fax Number	
Contact Name	E-mail	
Telephone	Fax Number	

Requires Original Signature of Provider

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

_____ Provider's Signature *(Required)*

_____ Date

Submit a copy of your IRS documentation along with these forms.

☐ Letter 147C ☐ Letter 147T ☐ Letter CP575 ☐ Deposit Coupon

Submission Instructions

Fax Fax the signed and completed form to Credentialing at **1-205-220-9545**	**Mail** **Blue Cross and Blue Shield of Alabama,** Attn: Credentialing Post Office Box 362142, Birmingham, AL 35236-2142