BlueCross BlueShield of Alabama

An Independent Licensee of the Blue Cross and Blue Shield Association

# DENTAL PROVIDER APPLICATION FORM

**Important – Please read the following information before completing the application**

This application alone does not entitle or guarantee participation in any Preferred Provider program offered by Blue Cross and Blue Shield of Alabama.

**Instructions:** Please PRINT or TYPE a response for each question. Please attach the copies of the documents and any additional information requested. Your responses will be used by the Credentialing Committee and will remain confidential. Please understand that these questions are asked of all participants.

☐ **Add New Provider** ☐ **Add a location**

## I. Personal Data (information provided in the following section will be validated through ADA and/or professional associations).

| Provider's LAST Name SUFFIX FIRST Name MIDDLE Initial | Professional Title | Social Security Number | Date of Birth (mm/dd/yyyy) | UPIN |
|---|---|---|---|---|
| | | | | |

| National Provider Identifier (NPI) | Primary Specialty | Board Certified? ☐ YES ☐ NO | Practicing Specialty (if different from Primary) | Board Certified? ☐ YES ☐ NO |
|---|---|---|---|---|
| | | | | |

| Original Date of Licensure | Alabama License Number (ATTACH COPY) | Languages You Speak *FLUENTLY* ☐ ENGLISH ☐ SPANISH ☐ FRENCH ☐ GERMAN ☐ OTHER |
|---|---|---|
| | | |

| Gender ☐ Male ☐ Female | Race and Ethnicity | Dental School | Date Graduated |
|---|---|---|---|
| | | | |

## II. Practice Data

| Location of Your Alabama Office: *Street Address Only - No P.O. Box* | *City* | *State* | *County* | *ZIP+4 Code* |
|---|---|---|---|---|
| | | | | |

| Correspondence Address: *Street Address - or - P.O. Box* | *City* | *State* | *County* | *ZIP+4 Code* |
|---|---|---|---|---|
| | | | | |

| Office Telephone (include area code) | Contact Person | Contact Person's Phone/Ext. (include area code) |
|---|---|---|
| | | |

| Office Fax (include area code) | Appointments Phone (include area code) | Email Address |
|---|---|---|
| | | |

Foreign languages spoken by staff ☐ English ☐ Spanish ☐ French ☐ German ☐ Sign ☐ Other

Is this office TDD available? ☐ YES ☐ NO

Does this location meet the Americans with Disabilities Act (ADA) standards? ☐ YES ☐ NO If Yes, check all that apply: ☐ Equipment ☐ Office ☐ Exam Room ☐ Parking

| Starting date at this location | If location is a hospital, what hospital? | Will you be providing Emergency Room Services? ☐ YES ☐ NO | Are you accepting new patients at this location? ☐ YES ☐ NO |
|---|---|---|---|
| | | | |

Do you have 24 Hour Coverage? ☐ YES ☐ NO Answering Machine? ☐ YES ☐ NO Answering Service? ☐ YES ☐ NO Emergency Room? ☐ YES ☐ NO Other? ☐ YES ☐ NO

If **yes**, please attach a list of covering physicians, including Physician Name, UPIN # and Effective Date of Coverage

Hospitals at Which You Have Admitting Privileges (*If needed, attach list and check here* ☐ )

| City | State | Hospital Name | Conditions of Privileges | Effective Date (MM/DD/YYYY) | % Admissions | Restrictions |
|---|---|---|---|---|---|---|
| | | | ☐ Full ☐ Temporary ☐ Courtesy ☐ None ☐ Applied/Pending | | | ☐ Yes ☐ No |
| | | | ☐ Full ☐ Temporary ☐ Courtesy ☐ None ☐ Applied/Pending | | | ☐ Yes ☐ No |

Daily Office Hours

| Sunday | Monday | Tuesday | Wednesday | Thursday | Friday | Saturday |
|---|---|---|---|---|---|---|
| ☐ AM ☐ PM | ☐ AM ☐ PM | ☐ AM ☐ PM | ☐ AM ☐ PM | ☐ AM ☐ PM | ☐ AM ☐ PM | ☐ AM ☐ PM |
| ___ ☐ PM | ___ ☐ PM | ___ ☐ PM | ___ ☐ PM | ___ ☐ PM | ___ ☐ PM | ___ ☐ PM |

## III. Payee/Remittance Information

| Name of Payee as reported to the IRS | Doing Business As |
|---|---|
| | |

| Federal Employer Identification Number as reported to the IRS | Payee/Remittance NPI | If Tax I.D. is changing, what is the effective date? |
|---|---|---|
| | | |

| Billing Office Phone/Ext. | Billing Office Fax Number | Billing Contact Person | Contact Phone Number |
|---|---|---|---|
| | | | |

| Billing/Remittance Address: | *City* | *State* | *County* | *ZIP+4 Code* |
|---|---|---|---|---|
| | | | | |

## IV. Practice Location Information (If you practice at additional locations, please provide information on a separate sheet. If applying for the PMD network, please refer to the Primary and Practicing Specialty Information sheet for determination of eligible specialties.)

| | Primary Practice Location | Secondary Practice Location | Third Practice Location |
|---|---|---|---|
| Provider Information | | | |
| Office Telephone (include area code) | | | |
| Appointment Telephone (include area code) | | | |
| Office Fax Number (include area code) | | | |
| E-mail Address | | | |
| Are you accepting new patients? | ☐ YES ☑ NO | ☐ YES ☑ NO | ☐ YES ☑ NO |
| Date of employment at this location | | | |
| Practice Name (DBA) | | | |
| Contact Person | | | |
| Practice Address – Street | | | |
| Practice Address – City, State, Zip | | | |
| Does this location meet the Americans with Disabilities Act (ADA) standards? | ☐ YES If yes, check all that apply: ☑ NO ☐ Equipment ☐ Office ☐ Exam Room ☐ Parking | ☐ YES If yes, check all that apply: ☑ NO ☐ Equipment ☐ Office ☐ Exam Room ☐ Parking | ☐ YES If yes, check all that apply: ☑ NO ☐ Equipment ☐ Office ☐ Exam Room ☐ Parking |
| Foreign Language Spoke by Staff | ☐ English ☐ Spanish ☐ Sign ☐ French ☐ German ☐ Other | ☐ English ☐ Spanish ☐ Sign ☐ French ☐ German ☐ Other | ☐ English ☐ Spanish ☐ Sign ☐ French ☐ German ☐ Other |
| TDD Available | ☐ YES ☑ NO | ☐ YES ☑ NO | ☐ YES ☑ NO |
| Primary Specialty at this Location | | | |
| Primary Specialty at this Location (if different from your primary specialty) | | | |
| Correspondence Address – Street | | | |
| Correspondence Address – City, State, Zip | | | |
| Legal Business Name (Payee) | | | |
| Payment/Remittance Address – Street | | | |
| Pmt/Remit Address – City, State, Zip | | | |
| Pmt/Remit Phone (include area code) | | | |
| Pmt/Remit Fax (include area code) | | | |
| Federal Taxpayer ID Number | | | |
| Payee/Remittance NPI | | | |
| Which income reporting form do you receive from your employer or the Internal Revenue Service at the end of the calendar year? | ☐ 1099 ☐ W-2 ☐ 1065-K1 | ☐ 1099 ☐ W-2 ☐ 1065-K1 | ☐ 1099 ☐ W-2 ☐ 1065-K1 |
| Taxpayer Name | | | |
| Tax Exempt? | ☐ YES - Attach copy of Exemption Certificate from IRS ☑ NO | ☑ YES - Attach copy of Exemption Certificate from IRS ☐ NO | ☐ YES - Attach copy of Exemption Certificate from IRS ☑ NO |
| Is this location address the same as your residence? | ☐ YES ☑ NO | ☐ YES ☑ NO | ☐ YES ☑ NO |
| Is this location an Urgicenter, After Hours or Urgicare Clinic? | ☐ YES ☑ NO | ☐ YES ☑ NO | ☐ YES ☑ NO |
| Is this location affiliated with or part of a rural health center? | Practice: Date: _____ | Practice: Date: _____ | Practice: Date: _____ |
| Is this location a nursing home? | ☐ YES: Name Tax ID# ☑ NO | ☐ YES: Name Tax ID# ☑ NO | ☐ YES: Name Tax ID# ☑ NO |
| Is this location a hospital? | ☐ YES: Name Tax ID# ☑ NO | ☐ YES: Name Tax ID# ☑ NO | ☐ YES: Name Tax ID# ☑ NO |

How many patients do you see at your **office** on an average day? How many patients do you see at the **hospital** on an average day?

## Primary Practice Information

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

## V. Questions and Answers (if the answer to any of the following questions 1-14 is **"Yes"**, please attach a detailed explanation of each situation)

**Within your years of practice:**

| | | | |
|---|---|---|---|
| 1. | Have you been convicted of a felony which was not overturned on appeal? | ☐ YES | ☒ NO |
| 2. | Do you have any restrictions of prescribing privileges due to sanctions or disciplinary measures? | ☐ YES | ☒ NO |
| 3. | Have you been subject to any disciplinary action from: a. State Licensure Board | ☐ YES | ☒ NO |
| | b. Local Medical Society | ☐ YES | ☒ NO |
| | c. Peer Review Organization | ☐ YES | ☒ NO |
| | d. Hospital Medical Staff (except failure to complete medical records) | ☐ YES | ☒ NO |
| 4. | Have you had any restrictions placed on your license/practice privileges due to disciplinary action of abuse of drugs/alcohol? | ☐ YES | ☒ NO |
| 5. | Have you been expelled or suspended from receiving Medicare or Medicaid payments? | ☐ YES | ☒ NO |
| 6. | Have you been expelled from a physician network, HMO, etc.? | ☐ YES | ☒ NO |
| 7. | Have you been restricted, suspended from or denied privileges by any hospital? | ☐ YES | ☒ NO |
| 8. | Have you voluntarily relinquished privileges? | ☐ YES | ☒ NO |
| 9. | Do you now or have you had a surcharge from you liability carrier? (if yes, specify amount of surcharge) | ☐ YES | ☒ NO |
| 10. | Have you had a judgement against you or a settlement in a professional liability case? | ☐ YES | ☒ NO |
| 11. | Do you currently have litigation pending against you involving the practice of medicine? | ☐ YES | ☒ NO |
| 12. | Do you currently owe Medicare or Blue Cross and Blue Shield an outstanding balance? | ☐ YES | ☒ NO |
| 13. | Do you have any physical, mental, or substance abuse problems that would impede your ability to perform according to accepted standards of professional performance or pose a threat to the health and safety of patients? | ☐ YES | ☒ NO |
| 14. | Has there been a gap of six months or more in your work history? | ☐ YES | ☒ NO |

## VI. Contact Information

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

| Last Name | Suffix | First | Middle |
|---|---|---|---|
| | | | |

| Phone Number | Fax Number | E-Mail Address |
|---|---|---|
| | | |

## VII. Practitioner Certification Section (Please keep a copy of this survey and all attachments for your records.)

I have read the contents of this survey and the information contained herein and all documents are 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 survey 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 Shield programs that apply to my provider type. I agree that any existing or future overpayment to me by Blue Shield may be recouped by Blue Shield through future payments. I understand that my name and my 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, as well as non-return of this Survey/Recredentialing Verification, could be grounds for termination. I understand that this survey alone does not entitle or guarantee participation in any Preferred Provider Program offered by Blue Cross and Blue Shield of Alabama. In the event I am selected to participate in any Preferred Provider Program offered by Blue Cross and Blue Shield of Alabama, this survey and all information will be incorporated by reference, and become part of any Preferred Provider Agreement. My signature here authorizes verification of the information I have provided.

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

| Printed Name of Provider | Provider's Signature | Date Signed |
|---|---|---|
| | | |

## 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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# 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. **Participation in any network listed below includes participation in the Blue Advantage® Network unless providers opt out below.**

| ✓ | Network | Eligible Provider | Network Status | Internal Use Only (Effective Date) |
|---|---|---|---|---|
| | **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** | ☐ Audiologist ☐ Occupational Therapist ☐ Physical Therapist ☐ Speech and Language Pathologist | Open | |
| | **Preferred Physician Laboratory (PPL)** | Physician in-house labs with CLIA Certification | Open | n/a |
| | **Physician Extender Networks –** Licensed | ☐ Anesthesia Assistant ☐ Nurse Midwife ☐ Certified Registered Nurse Anesthetist ☐ Nurse Practitioner ☐ Physician Assistant | Open | |
| | **Participating Licensed Registered Dietitian** | Dietitian | Open | |
| | **ALL Kids Participating –** ALL Kids Only | ☐ Ophthalmologist ☐ Opticians ☐ Optometrist | Open | |
| | **Preferred Dentist –** Statewide Dental Network | ☐ Dentists ☐ Oral Surgeons | Open | |
| | **Blue Advantage –** Medicare Advantage Program | Medicare Eligible Participating Providers | Open | |
| | **Preferred Sleep Medicine Program** | ☐ 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 |

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.

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;<br>2. The United States or any of its agencies or instrumentalities;<br>3. A state, the District of Columbia, a possession of the United States, or any of their political subdivisions;<br>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<br>2. I am not subject to backup withholding because:<br>a) I am exempt from backup withholdings, or<br>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<br>c) the IRS has notified me that I am no longer subject to backup withholdings, and<br>3. I am a U.S. person (including a U.S. resident alien).<br>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.