BlueCross BlueShield of Alabama

An Independent Licensee of the Blue Cross and Blue Shield Association

DENTAL PROVIDER APPLICATION FORM

Please complete application in full. Incomplete applications will be returned.

☐ Add New Provider | ☐ Add a location

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 ☐ M ☐ F	Dental School	Date Graduated

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 ( )	Contact Person	Contact Person's Phone/Ext. ( )

Office Fax ( )	Appointments Phone ( )	Email Address

Foreign languages spoken by staff ☐ English ☐ Spanish ☐ French ☐ German ☐ Sign ☐ Other	Is this office handicap accessible? ☐ YES ☐ NO	Is this office TDD available? ☐ YES ☐ NO

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	% Admissions	Restrictions
			☐ Full ☐ Temporary ☐ Courtesy ☐ None ☐ Applied/Pending	(MM/DD/YYYY)		☐ 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

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 Telephone ( )	Billing Office Fax Number ( )	Billing Contact Person	Contact Person's Phone/Ext. ( )

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

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

CONTINUED ON BACK

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
15.	Are you interested in being considered as a participant in the Alabama Preferred Dental Network?	☐ YES	☐ NO

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 Handwritten Signature	Date Signed

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PRACTITIONER 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. 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 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)
	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	☐ 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	
	ALL Kids Participating – ALL Kids Only	☐ Ambulance Providers ☐ 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 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.

Provider Name		Internal Use Only ☐☐☐ – ☐☐☐☐☐	
Individual NPI *(National Provider Identifier)* ☐☐☐☐☐☐☐☐☐☐		Organizational NPI ☐☐☐☐☐☐☐☐☐☐	
Practice Name		Tax ID Number ☐☐ – ☐☐☐☐☐☐☐	
E-mail	Office Phone		Fax Number
Office Address			
City	State	Zip	County
Mailing Address			
City	State	Zip	County
Provider Signature _____			Date _____

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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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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