



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	<input type="checkbox"/> Eye <input type="checkbox"/> Gastroentrology <input type="checkbox"/> 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	<input type="checkbox"/> ASC <input type="checkbox"/> DME <input type="checkbox"/> ESRD <input type="checkbox"/> Home Health <input type="checkbox"/> IDTF <input type="checkbox"/> Laboratory <input type="checkbox"/> Mental Health <input type="checkbox"/> Pharmacy <input type="checkbox"/> Portable Image <input type="checkbox"/> Rural Health <input type="checkbox"/> 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 <input style="width: 20px; height: 20px;" type="text"/> - <input style="width: 20px; height: 20px;" type="text"/>	
DBA	Organizational NPI <input style="width: 20px; height: 20px;" type="text"/>	
Contact Name	Tax ID Number <input style="width: 20px; height: 20px;" type="text"/> - <input style="width: 20px; height: 20px;" type="text"/>	
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
---	---



**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 <i>(Required)</i>			
Employer Identification Number	<input style="width: 100%;" type="text"/> - <input style="width: 100%;" type="text"/>	(or)	Social Security Number
	<input style="width: 100%;" type="text"/> - <input style="width: 100%;" type="text"/> - <input style="width: 100%;" type="text"/>		Effective Date
If you are a Sole Proprietor or Single-owner LLC			
Personal name of owner of business <i>(Required)</i>			
DBA (doing business as) if different from above <i>(Optional)</i>			

Part 2: Exemption
If exempt from form 1099 reporting, you must include a copy of your IRS exemption letter.
<ol style="list-style-type: none"> 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:			
<ol style="list-style-type: none"> 1. The number shown on this form is my correct taxpayer identification number, and 2. I am not subject to backup withholding because: <ol style="list-style-type: none"> 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 <i>(optional)</i>	
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.



HOSPITAL DATA FORM

This form is for hospital admitting privileges information only.

Provider Information form with fields for Provider Name, National Provider Identifier (NPI), Address, City, State, Zip, Phone, Fax Number, and E-mail.

I hereby attest that: (Check one please) ✓. Form with checkboxes for admitting privileges and fields for Specialty, Hospitalist Name, National Provider Identifier (NPI), Primary Hospital, City, State, Zip, and dates.

I also hereby grant permission to this hospital to verify and/or release my information including: List of 5 items and a statement of understanding.

Requires original signature of the physician. I certify this information is complete and correct to the best of my knowledge. Physician Signature and Date lines.

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

<input type="checkbox"/> I have admitting privileges at:	Hospital		
City	State	Zip	
Date my privileges were initially granted at this hospital: <i>(mm/dd/yyyy)</i>			
Next reappointment/review date to continue my privileges at this hospital is: <i>(mm/dd/yyyy)</i>			
My level of admitting privileges at this hospital is: <i>(check one)</i> <input type="checkbox"/> Full <input type="checkbox"/> Temporary <input type="checkbox"/> Courtesy <input type="checkbox"/> None			
<input type="checkbox"/> Applied/Pending Date Applied: <i>(mm/dd/yyyy)</i>		Expected date of Decision: <i>(mm/dd/yyyy)</i>	
My current standing at this hospital is: <i>(check one)</i> <input type="checkbox"/> Good standing with no issues <input type="checkbox"/> Restricted <input type="checkbox"/> Probationary			
<i>If you have any adverse actions from this hospital, including investigations or pending action, please attach a detailed explanation of the situation.</i>			
<input type="checkbox"/> I have admitting privileges at:	Hospital		
City	State	Zip	
Date my privileges were initially granted at this hospital: <i>(mm/dd/yyyy)</i>			
Next reappointment/review date to continue my privileges at this hospital is: <i>(mm/dd/yyyy)</i>			
My level of admitting privileges at this hospital is: <i>(check one)</i> <input type="checkbox"/> Full <input type="checkbox"/> Temporary <input type="checkbox"/> Courtesy <input type="checkbox"/> None			
<input type="checkbox"/> Applied/Pending Date Applied: <i>(mm/dd/yyyy)</i>		Expected date of Decision: <i>(mm/dd/yyyy)</i>	
My current standing at this hospital is: <i>(check one)</i> <input type="checkbox"/> Good standing with no issues <input type="checkbox"/> Restricted <input type="checkbox"/> Probationary			
<i>If you have any adverse actions from this hospital, including investigations or pending action, please attach a detailed explanation of the situation.</i>			
<input type="checkbox"/> I have admitting privileges at:	Hospital		
City	State	Zip	
Date my privileges were initially granted at this hospital: <i>(mm/dd/yyyy)</i>			
Next reappointment/review date to continue my privileges at this hospital is: <i>(mm/dd/yyyy)</i>			
My level of admitting privileges at this hospital is: <i>(check one)</i> <input type="checkbox"/> Full <input type="checkbox"/> Temporary <input type="checkbox"/> Courtesy <input type="checkbox"/> None			
<input type="checkbox"/> Applied/Pending Date Applied: <i>(mm/dd/yyyy)</i>		Expected date of Decision: <i>(mm/dd/yyyy)</i>	
My current standing at this hospital is: <i>(check one)</i> <input type="checkbox"/> Good standing with no issues <input type="checkbox"/> Restricted <input type="checkbox"/> Probationary			
<i>If you have any adverse actions from this hospital, including investigations or pending action, please attach a detailed explanation of the situation.</i>			



**BlueCross BlueShield
of Alabama**

An Independent Licensee of the Blue Cross and Blue Shield Association

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.	<div style="display: flex; justify-content: space-between;"> <div>_____</div> <div>_____</div> </div> <p style="text-align: center;">Provider's Signature <i>(Required)</i> Date</p>

Submit a copy of your IRS documentation along with these forms.
<input type="checkbox"/> Letter 147C <input type="checkbox"/> Letter 147T <input type="checkbox"/> Letter CP575 <input type="checkbox"/> 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



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.



**BlueCross BlueShield
of Alabama**

An Independent Licensee of the Blue Cross and Blue Shield Association

**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 <input type="checkbox"/> Checking <input type="checkbox"/> 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	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
If you have questions, please contact us at: 205-220-4745		

