BlueCross BlueShield of Alabama

An Independent Licensee of the Blue Cross and Blue Shield Association

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 Dept. 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

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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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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

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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.

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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

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