BlueCross BlueShield of Alabama

An Independent Licensee of the Blue Cross and Blue Shield Association

FACILITY BUSINESS 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.

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	☐ Single Specialty ☐ Multi-Specialty	Open
	Participating Dialysis	Dialysis	Open
	Preferred Medical Laboratory (PML)	Clinical Labs with CLIA Certification	Open
	Participating Hospital Network	Hospital	Open
	Blue Advantage – Medicare Advantage Program	☐ ASC ☐ DME ☐ Dialysis ☐ Home Health ☐ Hospital ☐ IDTF ☐ Laboratory ☐ RHC/FQHC ☐ SNF	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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