BlueCross BlueShield of Alabama

An Independent Licensee of the Blue Cross and Blue Shield Association

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

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

☐ 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)*

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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)*

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