BlueCross BlueShield of Alabama

An Independent Licensee of the Blue Cross and Blue Shield Association

NON PMD PROVIDER APPLICATION

Important – Please read the following information before completing the application

This application alone does not entitle or guarantee participation in any Preferred Provider program offered by Blue Cross and Blue Shield of Alabama.

Instructions: Please PRINT or TYPE a response for each question. Please attach the copies of the documents and any additional information requested. Your responses will be used by the Credentialing Committee and will remain confidential. Please understand that these questions are asked of all participants.

☐ **Add New Provider** ☐ **Add a location**

I. General Information

PROVIDER'S LAST NAME	SUFFIX	FIRST NAME	MIDDLE INITIAL	Preferred Name	Professional Title

Social Security Number	Unique Provider Identification No. (UPIN)	National Provider Identifier (NPI)	ECFMG Number

Date of Birth	County of Birth	State of Birth	Race and Ethnicity	Gender: ☐ MALE ☒ FEMALE

Federal DEA Number	Federal DEA Number Expiration Date	**Languages you speak fluently:** ☐ English ☐ Spanish ☐ French ☐ German ☐ Other	Country of Birth ☐ United States ☒

Are you a U.S. citizen? ☐ YES ☒ NO	**Legal right to work in the U.S.?** ☐ YES ☒ NO	Email Address

A. Medical Education (Attach additional sheets if necessary)

School Name	Dates attended; please include month/years Begin Date: (MM/YYYY) Ended: (MM/YYYY)			Degree Awarded
Street Address	**City**	**State**	**Zip**	**Country**

B. Postgraduate Education Training: Internship (Attach additional sheets if necessary)

Institution Name	Dates attended; please include month/years Begin Date: (MM/YYYY) Ended: (MM/YYYY)			Degree Awarded
Street Address	**City**	**State**	**Zip**	**Country**

C. Postgraduate Education Training: Residency/Fellowships

Residency Training Facility (Institution name)		Dates attended; please include month/years Begin Date: (MM/YYYY) Ended: (MM/YYYY)		
Street Address	**City**	**State**	**Zip**	**Country**

Residency Training Completion Date: *(if you have not yet completed residency, enter your expected completion date)*	Type of Residency/Fellowship

II. License Information (For the following state licensing information, write the name of the state in the top blank.)

Name of the State Licensed	1.	2.	3.	4.
State License Number				
Licensing Board				
Date Originally Licensed				
License Expiration Date				
State Medicare Provider #				
Number of Category 1 Continuing Medical Education (CME) hours completed yearly				

III. Specialty Information	Primary Specialty	Other Specialty	Other Specialty
Specialty Name			
Board Certification Status	☐ Certified ☒ Eligible ☒ Not Certified	☐ Certified ☒ Eligible ☒ Not Certified	☐ Certified ☒ Eligible ☒ Not Certified
Name of Board			
Certification Number			
Date Planning to Take Exam if Board Eligible			
Expiration Date			
Date of Recertification			

IV. Practice Location Information (If you practice at additional locations, please provide information on a separate sheet. If applying for the PMD network, please refer to the Primary and Practicing Specialty Information sheet for determination of eligible specialties.)

	Primary Practice Location	Secondary Practice Location	Third Practice Location
Contact Person			
Practice Name (DBA)			
Practice Address – Street			
Practice Address – City, State, Zip			
Office Telephone (include area code)			
Appointment Telephone (include area code)			
Office Fax Number (include area code)			
Primary Specialty at this Location			
Primary Specialty at this Location (if different from your primary specialty)			
Date of Employment at this Location			
Taxpayer Name			
Federal Taxpayer ID Number			
Payee/Remittance NPI			
Legal Business Name (Payee)			
Payment/Remittance Address – Street			
Pmt/Remit Address – City, State, Zip			
Pmt/Remit Phone (include area code)			
Pmt/Remit Fax (include area code)			
Correspondence Address – Street			
Correspondence Address – City, State, Zip			
Office E-mail Address			
Are you accepting new patients?	☐ YES ☒ NO ☐ Accepting all *(or check all that apply)* ☐ Blue Cross ☐ Blue Advantage ☐ Medicare ☐ Medicaid	☐ YES ☒ NO ☐ Accepting all *(or check all that apply)* ☐ Blue Cross ☐ Blue Advantage ☐ Medicare ☐ Medicaid	☐ YES ☒ NO ☐ Accepting all *(or check all that apply)* ☐ Blue Cross ☐ Blue Advantage ☐ Medicare ☐ Medicaid
Is this location address the same as your residence?	☐ YES - Attach copy of Business License and Zoning Permit ☒ NO	☐ YES - Attach copy of Business License and Zoning Permit ☒ NO	☐ YES - Attach copy of Business License and Zoning Permit ☒ NO
Does this location meet the Americans with Disabilities Act (ADA) standards?	☐ YES If yes, check all that apply: ☒ NO ☐ Equipment ☐ Office ☐ Exam Room ☐ Parking	☐ YES If yes, check all that apply: ☒ NO ☐ Equipment ☐ Office ☐ Exam Room ☐ Parking	☐ YES If yes, check all that apply: ☒ NO ☐ Equipment ☐ Office ☐ Exam Room ☐ Parking
Foreign Language Spoke by Staff	☐ English ☐ Spanish ☐ Sign ☐ French ☐ German ☐ Other	☐ English ☐ Spanish ☐ Sign ☐ French ☐ German ☐ Other	☐ English ☐ Spanish ☐ Sign ☐ French ☐ German ☐ Other
TDD Available	☐ YES ☒ NO	☐ YES ☒ NO	☐ YES ☒ NO
Which income reporting form do you receive from your employer or the Internal Revenue Service at the end of the calendar year?	☐ 1099 - Attach copy of Employment Contract ☐ W-2 ☐ 1065-K1	☐ 1099 - Attach copy of Employment Contract ☐ W-2 ☐ 1065-K1	☐ 1099 - Attach copy of Employment Contract ☐ W-2 ☐ 1065-K1
Is this location a nursing home?	☐ YES: Name ☒ NO Tax ID#	☐ YES: Name ☒ NO Tax ID#	☐ YES: Name ☒ NO Tax ID#
Is this location a hospital?	☐ YES: Name ☒ NO Tax ID#	☐ YES: Name ☒ NO Tax ID#	☐ YES: Name ☒ NO Tax ID#
In which setting will services be rendered?			

How many patients do you see at your **office** on an average day? How many patients do you see at the **hospital** on an average day?

V. Primary Practice Information

Daily Office hours	*Sunday*	*Monday*	*Tuesday*	Holidays Your Office Closes
	☐ AM ☐ PM _____ ☐ PM _____ ☐ PM	☐ AM ☐ PM _____ ☐ PM _____ ☐ PM	☐ AM ☐ PM _____ ☐ PM _____ ☐ PM	☐ New Year's Day ☐ Good Friday ☐ Memorial Day ☐ Independence Day ☐ Labor Day ☐ Thanksgiving ☐ Christmas Day ☐ Other
Wednesday	***Thursday***	***Friday***	***Saturday***	
☐ AM ☐ PM _____ ☐ PM _____ ☐ PM	☐ AM ☐ PM _____ ☐ PM _____ ☐ PM	☐ AM ☐ PM _____ ☐ PM _____ ☐ PM	☐ AM ☐ PM _____ ☐ PM _____ ☐ PM	

VI. Covering Physicians

Do you have physician coverage for your patients 24 hours per day, seven days per week? ☐ YES ☒ NO

If yes, type of coverage: ☐ Answering Service ☐ Answering Machine ☐ Emergency Room ☐ Other

List the physicians who cover for you. ***Please be sure to include the NPI (National Provider Identifier).***

National Provider Identifier (NPI)	Name of Covering Physician	Effective Date (MM/DD/YYYY)

VII. Hospital Admitting Privileges

List hospitals where you currently have admitting privileges. ***If you have any adverse actions from any of these hospitals, including investigations or pending actions, please attach a detailed explanation of the situation(s).***

City	State	Hospital Name and Hospital NPI	Conditions of Admitting Privileges	Effective Date of Privileges	Primary	Current Status
		Name: --- NPI:	☐ Full ☐ Temporary ☐ Courtesy ☐ Applied/Pending ☐ None	MM/DD/YYYY	☐ YES ☒ NO	☐ Good Standing ☐ Restricted ☐ Probation ☐ Suspended ☐ Terminated, effective
		Name: --- NPI:	☐ Full ☐ Temporary ☐ Courtesy ☐ Applied/Pending ☐ None	MM/DD/YYYY	☐ YES ☒ NO	☐ Good Standing ☐ Restricted ☐ Probation ☐ Suspended ☐ Terminated, effective

VIII. Malpractice Information

Name of professional liability carrier	Length of time with current carrier	Professional liability insurance aggregate	Professional liability per case
		$	$

XI. Question & Answer

If the answer to any of the following questions #1 – #14 is "Yes," please attach a detailed explanation of each situation.

1.	Have you ever 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:	☐ YES	☒ NO
	a. State Licensure Board	☐ YES	☒ NO
	b. Any professional organization	☐ YES	☒ NO
	c. Medicare or Medicaid	☐ YES	☒ NO
	d. Hospital Medical staff (except failure to complete medical records)	☐ YES	☒ NO
4.	Have you ever had any restrictions placed on your license or practice privileges due to disciplinary action for abuse of drugs or alcohol?	☐ YES	☒ NO
5.	Have you ever been expelled or suspended from receiving Medicare or Medicaid payments?	☐ YES	☒ NO
6.	Have you ever been expelled from a physician network, HMO, etc.?	☐ YES	☒ NO
7.	Have you ever been restricted or suspended from or denied privileges by any hospital not listed in Section VI on Page 3 of this application?	☐ YES	☒ NO
8.	Have you ever voluntarily relinquished privileges?	☐ YES	☒ NO
9.	Do you now or have you ever had a surcharge from your liability carrier? *(if yes, specify amount of surcharge)*	☐ YES	☒ NO
10.	Have you ever had a judgment 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 ever been a gap of six months or more in your work history?	☐ YES	☒ NO
15.	Do you utilize clinical pathways in your office practice?	☐ YES	☒ NO
16.	Does your practice utilize reference laboratories? *If yes, please specify:*	☐ YES	☒ NO
17.	Does your practice utilize the services of one of the following? *If yes, please indicate type:* ☐ Nurse Practitioner ☐ Physician Assistants ☐ Nurse Midwife ☐ Surgery Assistants ☐ Hospitalist ☐ Others? *Please specify:*	☐ YES	☒ NO
18.	Do you currently use an electronic practice management vendor?	☐ YES	☒ NO (*If yes, please name the Vendor)*
19.	Are you performing investigational clinical research?	☐ YES	☒ NO
20.	Are you a Medicare Participating Provider?	☐ YES	☒ NO

X. Contact Information

Please furnish the following information regarding a person we may contact in the event of any questions or additional information needs.

Last Name	Suffix	First	Middle

Phone Number	Fax Number	E-Mail Address

XI. Physician Certification Section (Please keep a copy of this application and all attachments for your records.)

I have read the contents of this application 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 application 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 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 could be grounds for termination. I understand that this application 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.

Printed Name of Provider	Provider's Handwritten Signature	Date Signed

This application alone does not entitle or guarantee participation in any Preferred Provider Program offered by Blue Cross and Blue Shield of Alabama.

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

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PRACTITIONER 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. Par Status follows the provider, and adding a location is for administrative and claims processing purposes only. 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 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
	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 *(Choose an option to the right.)*	☐ Audiologist ☐ Occupational Therapist ☐ Physical Therapist ☐ Speech and Language Pathologist	Open
	Preferred Physician Laboratory (PPL)	Physician in-house labs with CLIA Certification	Open
	Physician Extender Networks – Licensed *(Choose an option to the right.)*	☐ Anesthesia Assistant ☐ Nurse Midwife ☐ Nurse Practitioner ☐ Certified Registered Nurse Anesthetist ☐ Physician Assistant	Open
	Participating Licensed Registered Dietitian	Dietitian	Open
	ALL Kids Participating – ALL Kids Only *(Choose an option to the right.)*	☐ Ophthalmologist ☐ Opticians ☐ Optometrist	Open
	Preferred Dentist – Statewide Dental Network *(Choose an option to the right.)*	☐ Dentists ☐ Oral Surgeons	Open
	Blue Advantage – Medicare Advantage Program	Medicare Eligible Participating Providers	Open
	Preferred Sleep Medicine Program *(Choose an option to the right.)*	☐ 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 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.

Provider Name		Internal Use Only	
Individual NPI *(National Provider Identifier)*		Organizational NPI	
Practice Name		Tax ID Number	
Email	Office Phone	Fax Number	
Office Address			
City	State	Zip	County
Mailing Address			
City	State	Zip	County
Provider 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/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.