BlueCross BlueShield of Alabama

An Independent Licensee of the Blue Cross and Blue Shield Association

HOME CARE APPLICATION

Instructions

- *Please PRINT or TYPE a response for each question.*
- *Please attach the copies of the documents and any additional information requested.*
- *Please indicate N/A if a question is not applicable.*
- *Please understand that these questions are asked of all participants*
- *Your responses will be used by the Credentialing Committee and will remain confidential.*

☐ Add New Provider	☐ Update Existing Provider Information	☐ Add a Location	☐ Update Existing Location	Effective Date of Change (MM/DD/YYYY)

I. General Application Information

Check appropriate box:

☐ Initial Enrollment for Preferred or Participating Status ☐ Blue Shield Provider Number ☐ Change of Information ☐ Change of Ownership/Tax ID

If you are requesting initial enrollment for Preferred or Participating status, check the appropriate box:

☐ Participating Home Health Provider ☐ Participating Home Infusion Provider

II. Provider Identification

A. Corporate Information

Legal Business Name as Reported to the IRS		Business Supplier Name (DBA)	
Contact Name	Office Telephone	E-mail	
Corporate Address			Date Business Started
City		State	Zip
Office Telephone	Fax Number *(if applicable)*	E-mail	
Tax Identification Number			

B. Correspondence Address

Mailing Address Line 1		Mailing Address Line 2	
City		State	Zip
Office Telephone	Fax Number *(if applicable)*	E-mail	

C. Payment/Remittance Address

Mailing Address Line 1		Mailing Address Line 2	
City		State	Zip
Office Telephone	Fax Number *(if applicable)*	E-mail	
Payee/Remittance NPI			

III. Current Practice Locations

A. Practice Location Information

If there is more than one practice location, copy and complete this section for each. The addresses must be a specific street address. Do not furnish a Post Office Box.

Practice Location Name		Location NPI	
Practice Location Address Line 1		Practice Location Address Line 2	
City		State	Zip
Office Telephone	Fax Number *(if applicable)*	E-mail	

What foreign languages are spoken?:

Is this location handicapped accessible? ☐ Yes ☐ No

III. Current Practice Locations *(Continued)*

B. Location of Patient's Medical Records

Are all patients' medical records stored at the above address? ☐ Yes – *Skip to Section C.* ☒ No – *Complete this section.*

If any patient medical records are stored in a location other than the above address, complete this section with the name and address of the storage location.

Name of Storage Facility/Location		
Location Address Line 1	Location Address Line 2	
City	State	Zip

IV. 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

V. License Information

Is the agency licensed by the state of Alabama? ☐ Yes ☒ No

State Business License number	Original Date of License	License Renewal Date
County Business License number	Original Date of License	License Renewal Date
City Business License number	Original Date of License	License Renewal Date

VI. Ownership Information

Is your organization a subsidiary company or joint venture? ☐ Yes – *Complete this section* ☒ No – *Skip to Section A. – Individual Information*

Parent Company or Joint Venture Legal Name		Date Business Started
Employer ID Number	NPI Number	
Business Address Line 1	Business Address Line 2	
City	State	Zip
Office Telephone	Fax Number	E-mail

Ownership: *Please check all that apply to partners and/or stockholders with more than 10 percent interest.*

☐ City	☐ Hospital	☐ Sole Ownership	☐ For-Profit
☐ County	☐ Association	☐ Corporation	☐ Non-Profit
☐ State	☐ Foundation	☐ Partnership	
☐ Federal	☐ Church	☐ Other	

VI. Ownership Information *(Continued)*

A. Practice Location Information

Name *(First, Middle, Last, Jr., Sr., M.D., D.O., etc.)*		Date of Birth
Country of Birth	Social Security Number	UPIN/NPI Number

B. Other Organizations Ownership Information

Do you have ownership in other organizations that bill Blue Cross and Blue Shield of Alabama for services? ☐ Yes – *Complete this section* ☒ No – *Go to Section C*

Legal Business Name		Employer ID Number
Blue Cross and Blue Shield of Alabama Plan	Blue Cross and Blue Shield of Alabama Provider Number	UPIN/NPI Number

C. Program Exclusions

Have you ever been excluded from: ☐ Blue Shield ☒ None	**If so, indicate why?**
Period of Exclusion	Date of Reinstatement *(Attach a copy of reinstatement letter)*

VII. Billing Information

Will you be using a billing agency? ☐ YES – *Attach a copy of the signed contractual agreement with your billing agency and complete the remainder of this section.*
☒ No – *Skip to Section VIII.*

Name of Billing Agency	Employer ID Number	Contact Person
Business Address Line 1	Business Address Line 2	
City	State	Zip
Office Telephone	Fax Number	E-mail

VIII. Malpractice Information

Name of Professional Liability Carrier	Professional Liability Insurance Aggregate $
Length of Time with Current Carrier	Professional Liability Insurance Per Case $

IX. E-Practice Management Information

e-Practice Management is an electronic information network established and maintained by Blue Cross and Blue Shield of Alabama

Do you participate in the e-Practice Management Network? ☐ Yes ☒ No **If yes, what portion?** ☐ Patient Accounts (Eligibility and Benefits) ☐ Claims Processing

X. Professional Services

Are all professional staff members individually licensed, certified or registered to provide the services which they may be called on to render?

☐ Yes ☒ No – *Attach explanation.*

Does your agency service all counties in Alabama? ☐ Yes ☒ No

If no, list the counties served:

Please check all professional services provided directly by this home care agency. List subcontracted services below:

☐ Medical Social Services	☐ Occupational Therapy	☐ Respiratory Therapy	☐ Speech Therapy
☐ Skilled Nursing Services	☐ Diet or Nutritional Therapy	☐ Home Phototherapy	☐ Pediatric Nursing
☐ Physical Therapy	☐ Home Health Aid Services	☐ Home I.V. Therapy	☐ Other
☐ Infusion Suite	☐ Subcontracted Services:		

Accreditation		
Is this agency accredited? ☐ Yes ☐ No ☐ Pending	Date of Accreditation	Last Date Surveyed

☐ Joint Commission on Accreditation of Healthcare Organizations (JCAHO)
☐ Community Health Accreditation Program, Inc. (CHAPS)
☐ Accreditation Commission for Home Health Care, Inc. (ACHC)

XII. Required Information

Before mailing, you must include the following:

☐ A copy of your professional liability certificate of insurance from insurance company (Domestic carrier Required)
☐ A completed W-9 form
☐ A copy of an IRS letter identifying your tax name and number or a copy of your Federal Deposit Coupon, unless tax exempt
☐ A copy of all your business licenses and/or zoning permits
☐ A copy of the Medicare approval letter
☐ Accreditation certificate
☐ Network Interest Form – *Check all boxes that apply.*

XIII. Question & Answer

IMPORTANT: If any of the following questions are answered "Yes," please provide an explanation for each answer. If any questions do not apply to you, please answer ''No". Failure to check an answer or provide explanations for "Yes" responses may result in delay of application processing. All questions must be answered.

License Information

1. Has your organization ever been disciplined, reprimanded, or fined by any state board of medical examiners, professional conduct board, state or federal agency that disciplines organizations? ☐ Yes ☐ No
2. Has your license ever been denied, limited, suspended, revoked, or subject to probation or any conditions or limitations in any state? ☐ Yes ☐ No
3. Has your organization ever been disciplined, suspended, sanctioned, or otherwise restricted from participating in any private, federal or state health plan program (for example, Medicare, Medicaid, professional society or managed care organization) or is any such action pending? ☐ Yes ☐ No
4. Has your organization ever been the subject of any investigation by any private, federal, or state health program or is any such action pending? ☐ Yes ☐ No

Insurance Information

1. Has your professional liability insurance coverage ever been terminated or modified by action of any insurance company? ☐ Yes ☐ No
2. Has your organization ever been denied professional liability insurance coverage or rated in a higher-than average risk class for your specialty? ☐ Yes ☐ No
3. Have any professional liability suits, actions, or claims alleging malpractice ever been filed against your organization? ☐ Yes ☐ No
4. Are any professional liability suits, actions or claims currently pending against your organization? ☐ Yes ☐ No
5. Have any judgments ever been made against your organization in professional liability cases or claims, or have you ever entered into any settlements? ☐ Yes ☐ No
6. To your knowledge, has information pertaining to you or your organization ever been reported to the National Practitioner Data Bank? ☐ Yes ☐ No
7. Is your organization currently uninsured for professional liability staff (malpractice insurance) coverage? ☐ Yes ☐ No

Explanation:

XIV. Provider 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 is 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 Cross and Blue Shield programs that apply to my provider type. I agree that any existing or future overpayment to me by Blue Cross and Blue Shield may be recouped by Blue Cross and 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 Provider Program offered by Blue Cross and Blue Shield of Alabama. In the event I am selected to participate in any Participating or Preferred Provider Program offered by Blue Cross and Blue Shield of Alabama, this application and all information will be incorporated by reference, and become part of any Provider Agreement. My signature here authorizes verification of the information I have provided.

Printed Name of CEO	CEO's Handwritten Signature	Date Signed

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

Contact Name:		
Phone Number:	Fax Number:	Email:

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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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 Department 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

Blue Advantage® is a Medicare-approved PPO Plan provided by Blue Cross and Blue Shield of Alabama, an independent licensee of the Blue Cross and Blue Shield Association.

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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.