



**PARTICIPATING  
CHIROPRACTIC APPLICATION**

**Instructions: Please TYPE responses. This information will be used for your directory listing.**

In an effort to maintain a quality chiropractic program, it is necessary to ask some specific questions regarding your practice history. Submission of this form does not guarantee participation in this program.

<b>Add New Provider</b>	<b>Add a location</b>
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**I. Personal Information**

LAST Name	SUFFIX	FIRST Name	MIDDLE Initial	Title/Degree	Social Security Number
Personal E-Mail Address		NPI Number		Date of Birth	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
Professional License Number		License Issue Date	License Expiration Date	Primary Specialty	
Name of Chiropractic School		City, State and Zip of Chiropractic School			Year of Graduation
How many hours of continuing chiropractic education do you complete annually?			Languages You Speak <i>FLUENTLY</i> <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> French <input type="checkbox"/> German <input type="checkbox"/> Other		
Special or Extended Certifications					

**II. Malpractice Information**

Name of Professional Liability Carrier	Professional Liability Insurance Per Case \$	Professional Liability Insurance Aggregate \$
	Effective Date	Expiration Date

**III. Practice Information (Use separate sheets for additional office locations)**

Office Location: Street Address Only – No P.O. Box	City	State	County	ZIP+4
Correspondence Address: Street Address	City	State	County	ZIP+4
Office Phone Number (include area code)	Appointment Phone Number (include area code)	Office Fax Number (include area code)	Office E-mail Address	
<b>Daily Office hours</b>	<b>Sunday</b> <input type="checkbox"/> AM <input type="checkbox"/> PM <input type="checkbox"/> PM <input type="checkbox"/> PM	<b>Monday</b> <input type="checkbox"/> AM <input type="checkbox"/> PM <input type="checkbox"/> PM <input type="checkbox"/> PM	<b>Tuesday</b> <input type="checkbox"/> AM <input type="checkbox"/> PM <input type="checkbox"/> PM <input type="checkbox"/> PM	<b>Holidays Your Office Closes</b>
	<b>Wednesday</b> <input type="checkbox"/> AM <input type="checkbox"/> PM <input type="checkbox"/> PM <input type="checkbox"/> PM	<b>Thursday</b> <input type="checkbox"/> AM <input type="checkbox"/> PM <input type="checkbox"/> PM <input type="checkbox"/> PM	<b>Friday</b> <input type="checkbox"/> AM <input type="checkbox"/> PM <input type="checkbox"/> PM <input type="checkbox"/> PM	
<input type="checkbox"/> New Year's Day <input type="checkbox"/> Good Friday <input type="checkbox"/> Memorial Day <input type="checkbox"/> Independence Day <input type="checkbox"/> Labor Day <input type="checkbox"/> Thanksgiving <input type="checkbox"/> Christmas Day <input type="checkbox"/> Other				

**Handicap Accessible:**  YES  NO

**IV. Payee Information**

Name of Payee as Reported to the IRS	Doing Business As	Federal Employer Identification Number	
Payee Street Address:	City	State County ZIP+4	
Billing Office Telephone	Billing Office Fax Number	Billing Contact Person	Contact Person's Phone/Ext.
Tax ID	Organizational/Payee NPI	Office Start Date	

**V. Chiropractic Coverage**

Do you have 24 Hour Coverage?  YES  NO Answering Machine?  YES  NO Answering Service?  YES  NO Emergency Room?  YES  NO Other?  YES  NO  
If **yes**, please attach a list of covering chiropractors, including Chiropractor Name, UPIN # and Effective Date of Coverage

Name of Covering Chiropractor	NPI	Telephone Number (include area code)

**VI. Questions and Answers** (if the answer to any of the following questions 1-14 is "Yes", please attach a detailed explanation of each situation)

**Within your years of practice:**

1. Have you 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:
  - a. State Licensure Board  YES  NO
  - b. Local Chiropractic Society  YES  NO
  - c. Peer Review Organization  YES  NO
  - d. Hospital Medical Staff (except failure to complete medical records)  YES  NO
4. Have you had any restrictions placed on your license/practice privileges due to disciplinary action of abuse of drugs/alcohol?  YES  NO
5. Have you been expelled or suspended from receiving Medicare or Medicaid payments?  YES  NO
6. Have you been expelled from a physician network, HMO, etc.?  YES  NO
7. Have you been restricted, suspended from or denied privileges by any hospital?  YES  NO
8. Have you voluntarily relinquished privileges?  YES  NO
9. Do you now or have you had a surcharge from you liability carrier? (if yes, specify amount of surcharge)  YES  NO
10. Have you had a judgement 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 been a gap of six months or more in your work history?  YES  NO

**VII. 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	

**VIII. Chiropractor Certification Section** (Please keep a copy of this survey 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.

I certify this information is complete and correct to the best of my knowledge.

_____ Printed Name of Provider	_____ Provider's Signature	_____ Date Signed
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**Submission Instructions**

<b>Fax</b> Fax the signed and completed form to: Attn: Credentialing <b>1-205-220-9545</b>	<b>Mail</b> <b>Blue Cross and Blue Shield of Alabama</b> , Attn: Credentialing Post Office Box 362142, Birmingham, AL 35236-2142
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# PRACTITIONER 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. 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. **Participation in any network listed below includes participation in the Blue Advantage® Network unless providers opt out below.**

✓	Network	Eligible Provider	Network Status	Internal Use Only (Effective Date)
	<b>Preferred Medical Doctor (PMD) Program</b>	MDs and DOs (excludes Psychiatry)	Open	
	<b>Preferred Optometry Network</b>	Optometrist	Open	
	<b>Preferred Podiatry Network</b>	Podiatrist	Open	
	<b>Participating Chiropractor Network</b>	Chiropractors	Open	
	<b>Preferred Therapy Network</b>	Audiologist    Occupational Therapist Physical Therapist    Speech and Language Pathologist	Open	
	<b>Preferred Physician Laboratory (PPL)</b>	Physician in-house labs with CLIA Certification	Open	n/a
	<b>Physician Extender Networks – Licensed</b>	Anesthesia Assistant    Nurse Midwife Certified Registered Nurse Anesthetist Nurse Practitioner    Physician Assistant	Open	
	<b>Participating Licensed Registered Dietitian</b>	Dietitian	Open	
	<b>ALL Kids Participating – ALL Kids Only</b>	Ophthalmologist    Opticians    Optometrist	Open	
	<b>Preferred Dentist – Statewide Dental Network</b>	Dentists    Oral Surgeons	Open	
	<b>Blue Advantage – Medicare Advantage Program</b>	Medicare Eligible Participating Providers	Open	
	<b>Preferred Sleep Medicine Program</b>	In Home Accredited    In Lab Accredited	Open	
<b>NO – I am not interested in participating in any Blue Cross network.</b>				

### 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.

<b>Provider Name</b>	Internal Use Only
Individual NPI <i>(National Provider Identifier)</i>	Organizational NPI
Practice Name	Tax ID Number

Email	Office Phone	Fax Number
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### Office Address

City	State	Zip	County
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### Mailing Address

City	State	Zip	County
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Provider Signature	Date
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### Submission Instructions

<b>Fax:</b> Fax the signed and completed form to: Attn: Credentialing <b>1-205-220-9545</b>	<b>Mail:</b> 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.

<b>Part 1: Tax Status</b>			
<b>Name</b> as it appears on Internal Revenue Service (IRS) Records <i>(Required)</i>			
Employer Identification Number	(or)	Social Security Number	Effective Date
<b>If you are a Sole Proprietor or Single-owner LLC</b>			
Personal name of owner of business <i>(Required)</i>			
DBA (doing business as) if different from above <i>(Optional)</i>			

<b>Part 2: Exemption</b>
<b>If exempt from form 1099 reporting, you must include a copy of your IRS exemption letter.</b>
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.

<b>Part 3: Certification</b>			
<b>Under penalties of perjury, I certify that:</b>			
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			
<b>Name of person completing this form</b>			
<b>Signature</b>			<b>Date</b>
Telephone	Fax	E-mail <i>(optional)</i>	
<b>Tax Address</b>			
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.