BlueCross BlueShield of Alabama

PHYSICIAN EXTENDER APPLICATION

Instructions: Please PRINT or TYPE a response for each question. Please attach the copies of the documents and any additional information requested.

☐ Add New Provider ☐ Add a location

Practitioner Information

General Information

Last Name	Suffix	First Name	Middle Initial	Preferred Name	Professional Title

Social Security Number	Race and Ethnicity	National Provider Identifier (NPI)	Email Address

Date of Birth	County of Birth	State of Birth	Country of Birth ☐ United States ☐	Gender: ☐ MALE ☐ FEMALE

Are you a U.S. citizen? ☐ YES ☐ NO | If No, Alien Registration Number | **Legal right to work in the U.S.?** ☐ YES ☐ NO

Are you fluent in any languages other than English? ☐ Spanish ☐ French ☐ German ☐ Italian ☐ Arabic ☐ Chinese ☐ Japanese ☐ Other language

If your professional license has ever been issued under a name other than the name listed above (e.g. maiden name, alias, nicknames) please indicate below:

Last Name	Suffix	First Name	Middle Initial

Primary Practice Information (For additional locations, see page two.)

Legal Practice Name		Doing Business As (DBA)			Practice Start Date

Tax ID	Tax ID Start Date	Office Email Address

Street Address	Suite/ Building	City	State	Zip	County

Office Telephone Number (include area code)	Appointment Telephone Number (include area code)	Office Fax Number (include area code)

Is a Telephone Device for the Deaf (TDD) available? ☐ YES ☐ NO | If Yes, TDD Telephone Number (include area code)

Contact First Name	Middle Name	Last Name	Suffix	Title

Office Practice Type? ☐ Individual ☐ Group | Primary Practicing Specialty | Secondary Practicing Specialty

Does this location meet the Americans with Disabilities Act (ADA) standards? ☐ YES ☐ NO If Yes, check all that apply: ☐ Equipment ☐ Office ☐ Exam Room ☐ Parking

Accepting new patients? ☐ YES ☐ NO | ☐ Accepting all *(or check all that apply)* ☐ Blue Cross ☐ Blue Advantage ☐ Medicare ☐ Medicaid

If all, list the Medicare and Medicaid Numbers	Medicare Number	Medicaid Number

Languages spoken by staff in addition to English? ☐ Spanish ☐ French ☐ German ☐ Italian ☐ Arabic ☐ Chinese ☐ Japanese ☐ Other language

Is this location an Urgicenter, After Hours or Urgicare Clinic? ☐ YES ☐ NO | **Will you be providing Emergency Room Services?** ☐ YES ☐ NO

Are there age limitations on your patients? ☐ YES ☐ NO | If Yes, please specify from years to

CLIA Certificate Number	CLIA Expiration Date (MM/DD/YYYY)	**CLIA Waiver?** ☐ YES ☐ NO

Do you perform surgery in your office? ☐ YES ☐ NO | **Is your location a residence?** ☐ YES ☐ NO

If Yes, list the Medicare and Medicaid Numbers	Medicare Number	Medicaid Number

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

Correspondence Address ☐ Is this address the same as the office practice address?

Street Address	Suite/ Building	City	State	Zip	County

Billing Address ☐ Is this address the same as the office practice address?

Is this a billing agency? ☐ YES ☐ NO | If Yes, name | Billing NPI | Billing NPI Effective Date (MM/DD/YYYY)

Street Address	Suite/ Building	City	State	Zip	County

Office Telephone Number (include area code)	Office Fax Number (include area code)	Office Email Address

Additional Practice Locations (Attach additional sheets if necessary)

	Practice Location	Practice Location	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			
E-mail Address			
Are you accepting new patients?	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
	☐ Accepting all *(or check all that apply)* ☐ Blue Cross ☐ Blue Advantage ☐ Medicare ☐ Medicaid	☐ Accepting all *(or check all that apply)* ☐ Blue Cross ☐ Blue Advantage ☐ Medicare ☐ Medicaid	☐ Accepting all *(or check all that apply)* ☐ Blue Cross ☐ Blue Advantage ☐ Medicare ☐ Medicaid
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 ☐ W-2 ☐ 1065-K1	☐ 1099 ☐ W-2 ☐ 1065-K1	☐ 1099 ☐ W-2 ☐ 1065-K1
Is this location address the same as your residence?	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
Is this location an Urgicenter, After Hours or Urgicare Clinic?	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
Is this location affiliated with or part of a rural health center?	Practice: Date:	Practice: Date:	Practice: Date:
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#

Collaborative/Supervising Physicians

First Name	Middle Name	Last Name	Suffix	National Provider Identifier (NPI)

Specialty	Office Telephone Number (include area code)	Office Fax Number (include area code)	Email Address

Professional Liability (Please list your Insurance Carrier (Domestic Insurer Only), beginning with the most current.)

Carrier Name	Indicate if this carrier is your ☐ Current Carrier ☐ Previous Carrier ☐ State Insurance Fund

Street Address	Suite/Building	City	State	Zip	County

Office Telephone Number (include area code)	Office Fax Number (include area code)	Office Email Address

Certificate Number	Effective Date (MM/DD/YYYY)	Expiration Date (MM/DD/YYYY)	Time with Carrier (Years and Months)

Amount of Coverage/Occurrence	☐ Unlimited Coverage	Amount of Coverage/Aggregate	☐ Unlimited Coverage

State Medical License

In the State of	☐ I hold a valid Medical License	☐ I am in the process of applying for a Medical License

License/Certificate Number	Issue Date (MM/DD/YYYY)	Expiration Date (MM/DD/YYYY)	Does this license/certification level require supervision? ☐ YES ☐ NO

Board Description

Additional State Medical License

In the State of	☐ I hold a valid Medical License	☐ I am in the process of applying for a Medical License

License/Certificate Number	Issue Date (MM/DD/YYYY)	Expiration Date (MM/DD/YYYY)	Does this license/certification level require supervision? ☐ YES ☐ NO

Board Description

Additional State Medical License

In the State of	☐ I hold a valid Medical License	☐ I am in the process of applying for a Medical License

License/Certificate Number	Issue Date (MM/DD/YYYY)	Expiration Date (MM/DD/YYYY)	Does this license/certification level require supervision? ☐ YES ☐ NO

Board Description

Medical Education (Attach additional sheets if necessary)

School Name	Dates attended; please include month/years Begin Date: (MM/YYYY) Ended: (MM/YYYY)

Street Address	City	State	Zip	Country

Did you complete your medical school or medical training in a foreign country? ☐ YES ☐ NO

Degree Type? ☐ AA ☐ CNM ☐ CNSA ☐ CRNA ☐ CSA ☐ LPN ☐ NP ☐ PA ☐ RN ☐ Other

Additional Education

School Name	Dates attended; please include month/years Begin Date: (MM/YYYY) Ended: (MM/YYYY)

Street Address	City	State	Zip	Country

Did you complete your medical school or medical training in a foreign country? ☐ YES ☐ NO

Degree Type? ☐ AA ☐ CNM ☐ CNSA ☐ CRNA ☐ CSA ☐ LPN ☐ NP ☐ PA ☐ RN ☐ Other

Additional Education

School Name	Dates attended; please include month/years Begin Date: (MM/YYYY) Ended: (MM/YYYY)

Street Address	City	State	Zip	Country

Did you complete your medical school or medical training in a foreign country? ☐ YES ☐ NO

Degree Type? ☐ AA ☐ CNM ☐ CNSA ☐ CRNA ☐ CSA ☐ LPN ☐ NP ☐ PA ☐ RN ☐ Other

Board Certification (Please add an entry for each Specialty Board and Certificate)

Specialty Board		Certificate	
Certificate Number	Original Certification Date (MM/DD/YYYY)	Last Certification Date (MM/DD/YYYY)	Current Expiration Date (MM/DD/YYYY)

☐ I am in the process of taking specialty boards and my exam date is (MM/DD/YYYY):

Have you ever taken the Board Certifications and failed? ☐ YES ☐ NO

☐ I am not planning to take specialty boards. Please provide a brief explanation.

☐ I am not eligible to take specialty boards. Please provide a brief explanation.

Additional Board Certification

Specialty Board		Certificate	
Certificate Number	Original Certification Date (MM/DD/YYYY)	Last Certification Date (MM/DD/YYYY)	Current Expiration Date (MM/DD/YYYY)

☐ I am in the process of taking specialty boards and my exam date is (MM/DD/YYYY):

Have you ever taken the Board Certifications and failed? ☐ YES ☐ NO

☐ I am not planning to take specialty boards. Please provide a brief explanation.

☐ I am not eligible to take specialty boards. Please provide a brief explanation.

Additional Board Certification

Specialty Board		Certificate	
Certificate Number	Original Certification Date (MM/DD/YYYY)	Last Certification Date (MM/DD/YYYY)	Current Expiration Date (MM/DD/YYYY)

☐ I am in the process of taking specialty boards and my exam date is (MM/DD/YYYY):

Have you ever taken the Board Certifications and failed? ☐ YES ☐ NO

☐ I am not planning to take specialty boards. Please provide a brief explanation.

☐ I am not eligible to take specialty boards. Please provide a brief explanation.

Professional Practice History (Please account for your professional practice history (other than hospital affiliations), from graduate school to present, including any military experience, if applicable.)

Office Practice/Institution Name				Position/Rank	
Dates; please include month/years Begin Date: (MM/YYYY) Ended: (MM/YYYY)		**Is this a current affiliation?** ☐ YES ☐ NO			
Street Address	Suite/Building	City	State	Zip	Country

Additional Professional Practice History (Please account for your professional practice history (other than hospital affiliations), from graduate school to present, including any military experience, if applicable.)

Office Practice/Institution Name				Position/Rank	
Dates; please include month/years Begin Date: (MM/YYYY) Ended: (MM/YYYY)		**Is this a current affiliation?** ☐ YES ☐ NO			
Street Address	Suite/Building	City	State	Zip	Country

Additional Professional Practice History (Please account for your professional practice history (other than hospital affiliations), from graduate school to present, including any military experience, if applicable.)

Office Practice/Institution Name				Position/Rank	
Dates; please include month/years Begin Date: (MM/YYYY) Ended: (MM/YYYY)		**Is this a current affiliation?** ☐ YES ☐ NO			
Street Address	Suite/Building	City	State	Zip	Country

Prescribing Authority

Federal Drug Enforcement Administration (DEA) License

I have State certification ☐ YES ☐ NO If Yes, number and dates	Certificate Number	Original Certification Date (MM/DD/YYYY)	Expiration Date (MM/DD/YYYY)
I am in the process of applying for State certification ☐ YES ☐ NO		Please indicate all schedules currently held ☐ 2 ☐ 2N ☐ 3 ☐ 3N ☐ 4 ☐ 5	

Is this certification Limited or Restricted? ☐ YES ☐ NO If Yes, please explain

State Drug License

I have State certification ☐ YES ☐ NO If Yes, number and dates	Certificate Number	Original Certification Date (MM/DD/YYYY)	Expiration Date (MM/DD/YYYY)
I am in the process of applying for State certification ☐ YES ☐ NO		Please indicate all schedules currently held ☐ 2 ☐ 2N ☐ 3 ☐ 3N ☐ 4 ☐ 5	

Is this certification Limited or Restricted? ☐ YES ☐ NO If Yes, please explain

Questions and Answers

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.

Education and Training

1. During your education, internship, residency, fellowship, preceptorship or additional training, as applicable were you ever disciplined, suspended, placed on probation, formally reprimanded, or asked to resign? ☐ YES ☐ NO

License Information

2. Have you ever been disciplined, reprimanded, or fined by any state board of medical examiners, professional conduct board, or state of federal agency that disciplines physicians or allied health professionals? ☐ YES ☐ NO
3. Has your license to practice, in your profession, ever been denied, limited, suspended, revoked, or subject to probation or any conditions or limitations in any state? ☐ YES ☐ NO
4. Have you ever been disciplined, suspended, sanctioned, or otherwise restricted from participating in any private, federal or state health plan program (for example, Medicare, Medicaid, CLIA, professional society or managed care organization) or is any such action pending? ☐ YES ☐ NO
5. Have you ever been the subject of any investigation by any private, federal, or state health program or is any such action pending? ☐ YES ☐ NO
6. Have your Federal DEA and/or State Controlled Dangerous Substance (CDS) Certificate(s) ever been voluntarily or involuntarily limited, suspended, revoked, relinquished, or not renewed or are proceedings currently pending? ☐ YES ☐ NO

Insurance Information

7. Has your professional liability insurance coverage ever been terminated or modified by action of any insurance company? ☐ YES ☐ NO
8. Have you ever been denied professional liability insurance coverage or rated in a higher-than average risk class for your specialty? ☐ YES ☐ NO
9. Have any professional liability suits, actions, or claims alleging malpractice ever been filed against you? ☐ YES ☐ NO
10. Are any professional liability suits, actions or claims currently pending against you? ☐ YES ☐ NO
11. Have any judgments ever been made against you in professional liability cases or claims, or have you ever entered into any settlements? ☐ YES ☐ NO
12. To your knowledge, has information pertaining to you ever been reported to the National Practitioner Data Bank?? ☐ YES ☐ NO
13. Are you currently uninsured for professional liability staff (malpractice insurance) coverage? ☐ YES ☐ NO

Board Certification

14. Has your Specialty Board certification or eligibility ever been denied, revoked, relinquished, not renewed, suspended, or reduced or have any proceedings toward those ends been instituted? ☐ YES ☐ NO

Practice History

15. Are there any gaps in your professional practice history? ☐ YES ☐ NO
16. Do you have or have you had a chemical dependency and/or substance abuse problem, treated or untreated? ☐ YES ☐ NO
17. During the last three years have you ever been under the influence of alcohol during working hours, or have you had a chemical dependency and/or substance abuse problem, treated or untreated? ☐ YES ☐ NO
18. Are you unable, with or without reasonable accommodation, to practice to the fullest extent of your license, qualification, and privileges without in any way posing a risk of harm to your patients? ☐ YES ☐ NO

Criminal History

19. Have you ever been arrested for, or charged with, a crime involving children? If "Yes," include the disposition of the arrest or charge on a separate sheet. This statement is being answered under penalty of perjury, subject to applicable Federal punishment of perjury? ☐ YES ☐ NO
20. Have you ever been convicted of a felony or are you presently under investigation or have you ever been indicted for a felony? ☐ YES ☐ NO

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

Provider Authorization (Please keep a copy of this application and all attachments for your records.)

I hereby give permission to the selected entities and/or its designee to request information regarding my professional credentials and qualifications from educational facilities, the chief(s) of the clinical department(s) of the hospital(s) in which I currently have or formerly have had medical staff membership and/or clinical privileges, professional certification boards, state regulatory and licensing departments, professional liability insurance carriers, other professional monitoring entities, and present and past employers.

The information requested may include otherwise privileged or confidential material relative to my professional qualifications, credentials, claims history, clinical and/or professional competence, character, ethics, or any other matter having bearing on the credentialing procedure. I release and agree to hold harmless the selected entities and its affiliates to whom this information is given and their representatives, employees and agents from any and all liability for any damages, costs, and expenses which may result from the gathering or use of such information, as long as such release or use of information is done in good faith and without malice.

I hereby authorize the educational facilities, the chief(s) of the clinical department(s) of the hospital(s) in which I currently have or formerly have had staff privileges, professional certification boards, state regulatory and licensing departments, professional liability carriers, other professional monitoring entities and present and past employers to submit information requested by the selected entities including otherwise privileged or confidential material relative to my professional qualifications, credentials, past and present malpractice coverage, claims and suit information, clinical and/or professional competence, character, ethics, or any other matter having bearing on the credentialing procedure. I hereby further release and agree to hold harmless all such entities, their representatives, employees and agents from any and all liability for any damages which may result from providing this information, as long as such release or use of this information is done in good faith and without malice. I further agree the burden shall be upon me to prove such release was done in bad faith and with malice by a preponderance of evidence.

I agree that a photocopy or facsimile of this document with my signature may be accepted by any person or entity from which such information is sought with the same authority as the original and I specifically waive written notice from any such entities or individuals who may provide information based upon this authorized request.

I represent that the information provided in or attached to this Application and the most current information provided to the selected entities is accurate and complete. I understand that a condition of this Application is that any misrepresentation, misstatement or omission from this Application, whether intentional or not, is cause for automatic and immediate rejection of this Application by the selected entities and may result in denial of my application or termination of my participation in the selected entities. I further understand that any misrepresentation, misstatement or omission from this Application, if discovered after participation has been awarded to me, may lead to immediate suspension or termination of those privileges. I agree to use my best efforts to inform the selected entities in writing within 30 days if there is any change in the information provided or the answers to questions on the Application as a result to developments subsequent to my signing this Application.

I warrant that I have the authority to sign this Application, on my behalf, and on behalf of any entity or organization for which I am signing in a representative capacity. I agree that submission of this Application does not constitute approval or acceptance of this application or me by the entity as a participating provider. I further agree that this application may only qualify as a "pre-application" under the rules of the entity.

I understand that if my application is rejected for reasons relating to my professional conduct or clinical competence, the selected entities may be required to report the rejection to the appropriate state licensing board and/or National Practitioner Data Bank.

This attestation statement must be signed no more than 180 days prior to the credentialing decision. If the credentialing review and decision takes place more than 180 days after the signature below, provider must re-sign and date this application page attesting that all application page attesting that all application information remains current, complete and correct.

☐ *I have reviewed and **AGREE** to this attestation statement*

☐ *I have reviewed and **DO NOT AGREE** to this attestation statement*

I UNDERSTAND THAT THIS APPLICATION DOES NOT ENTITLE ME TO PARTICIPATION IN ANY HOSPITAL, HEALTH CARE ENTITY, OR HEALTH PLAN.

The undersigned, being hereby warned that intentional or unintentional false statements and the like so made may jeopardize the validity of the application, declares that he/she is properly authorized to execute this application; and that all statements made of his/her own knowledge are true; and that all statements made on information and belief are believed to be true.

Printed Name of Provider	Provider's Handwritten Signature	Date Signed

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

BlueCross BlueShield of Alabama

An Independent Licensee of the Blue Cross and Blue Shield Association

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

BlueCross BlueShield of Alabama

An Independent Licensee of the Blue Cross and Blue Shield Association

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.