



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.

<input type="checkbox"/> Add New Provider					<input type="checkbox"/> Add a location				
Practitioner Information									
General Information									
Last Name		Suffix	First Name		Middle Initial	Preferred Name		Professional Title	
Social Security Number			National Provider Identifier (NPI)			Email Address			
Date of Birth	County of Birth		State of Birth		Country of Birth		<input type="checkbox"/> United States <input type="checkbox"/>	Gender: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	
Are you a U.S. citizen? <input type="checkbox"/> YES <input type="checkbox"/> NO			If No, Alien Registration Number			Legal right to work in the U.S.? <input type="checkbox"/> YES <input type="checkbox"/> NO			
Are you fluent in any languages other than English? <input type="checkbox"/> Spanish <input type="checkbox"/> French <input type="checkbox"/> German <input type="checkbox"/> Italian <input type="checkbox"/> Arabic <input type="checkbox"/> Chinese <input type="checkbox"/> Japanese <input type="checkbox"/> 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? <input type="checkbox"/> YES <input type="checkbox"/> NO				If Yes, TDD Telephone Number (include area code)					
Contact First Name		Middle Name		Last Name		Suffix	Title		
Office Practice Type? <input type="checkbox"/> Individual <input type="checkbox"/> Group		Primary Practicing Specialty			Secondary Practicing Specialty			Handicap Access? <input type="checkbox"/> YES <input type="checkbox"/> NO	
Accepting new patients? <input type="checkbox"/> YES <input type="checkbox"/> NO		Accepting all (or check all that apply) <input type="checkbox"/> Blue Cross <input type="checkbox"/> Blue Advantage <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid							
If all, list the Medicare and Medicaid Numbers			Medicare Number			Medicaid Number			
Languages spoken by staff in addition to English? <input type="checkbox"/> Spanish <input type="checkbox"/> French <input type="checkbox"/> German <input type="checkbox"/> Italian <input type="checkbox"/> Arabic <input type="checkbox"/> Chinese <input type="checkbox"/> Japanese <input type="checkbox"/> Other language									
Is this location an Urgicenter, After Hours or Urgicare Clinic? <input type="checkbox"/> YES <input type="checkbox"/> NO				Will you be providing Emergency Room Services? <input type="checkbox"/> YES <input type="checkbox"/> NO					
Are there age limitations on your patients? <input type="checkbox"/> YES <input type="checkbox"/> NO			If Yes, please specify from _____ years to _____						
CLIA Certificate Number		CLIA Expiration Date (MM/DD/YYYY)			CLIA Waiver? <input type="checkbox"/> YES <input type="checkbox"/> NO				
Do you perform surgery in your office? <input type="checkbox"/> YES <input type="checkbox"/> NO			Is your location a residence? <input type="checkbox"/> YES <input type="checkbox"/> NO						
If Yes, list the Medicare and Medicaid Numbers			Medicare Number			Medicaid Number			
Daily Office hours	Sunday <input type="checkbox"/> AM <input type="checkbox"/> PM <input type="checkbox"/> PM <input type="checkbox"/> PM		Monday <input type="checkbox"/> AM <input type="checkbox"/> PM <input type="checkbox"/> PM <input type="checkbox"/> PM		Tuesday <input type="checkbox"/> AM <input type="checkbox"/> PM <input type="checkbox"/> PM <input type="checkbox"/> PM		Holidays Your Office Closes		
Wednesday <input type="checkbox"/> AM <input type="checkbox"/> PM <input type="checkbox"/> PM <input type="checkbox"/> PM	Thursday <input type="checkbox"/> AM <input type="checkbox"/> PM <input type="checkbox"/> PM <input type="checkbox"/> PM		Friday <input type="checkbox"/> AM <input type="checkbox"/> PM <input type="checkbox"/> PM <input type="checkbox"/> PM		Saturday <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	
Correspondence Address <input type="checkbox"/> Is this address the same as the office practice address?									
Street Address		Suite/ Building	City		State	Zip	County		
Billing Address <input type="checkbox"/> Is this address the same as the office practice address?									
Is this a billing agency? <input type="checkbox"/> YES <input type="checkbox"/> 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?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
	<input type="checkbox"/> Accepting all (or check all that apply) <input type="checkbox"/> Blue Cross <input type="checkbox"/> Blue Advantage <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid	<input type="checkbox"/> Accepting all (or check all that apply) <input type="checkbox"/> Blue Cross <input type="checkbox"/> Blue Advantage <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid	<input type="checkbox"/> Accepting all (or check all that apply) <input type="checkbox"/> Blue Cross <input type="checkbox"/> Blue Advantage <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid
Handicap Accessible	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Foreign Language Spoke by Staff	<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Sign <input type="checkbox"/> French <input type="checkbox"/> German <input type="checkbox"/> Other	<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Sign <input type="checkbox"/> French <input type="checkbox"/> German <input type="checkbox"/> Other	<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Sign <input type="checkbox"/> French <input type="checkbox"/> German <input type="checkbox"/> Other
TDD Available	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Which income reporting form do you receive from your employer or the Internal Revenue Service at the end of the calendar year?	<input type="checkbox"/> 1099 <input type="checkbox"/> W-2 <input type="checkbox"/> 1065-K1	<input type="checkbox"/> 1099 <input type="checkbox"/> W-2 <input type="checkbox"/> 1065-K1	<input type="checkbox"/> 1099 <input type="checkbox"/> W-2 <input type="checkbox"/> 1065-K1
Is this location address the same as your residence?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Is this location an Urgicenter, After Hours or Urgicare Clinic?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Is this location affiliated with or part of a rural health center?	Practice: Date:		
Is this location a nursing home?	<input type="checkbox"/> YES: Name <input type="checkbox"/> NO Tax ID#	<input type="checkbox"/> YES: Name <input type="checkbox"/> NO Tax ID#	<input type="checkbox"/> YES: Name <input type="checkbox"/> NO Tax ID#
Is this location a hospital?	<input type="checkbox"/> YES: Name <input type="checkbox"/> NO Tax ID#	<input type="checkbox"/> YES: Name <input type="checkbox"/> NO Tax ID#	<input type="checkbox"/> YES: Name <input type="checkbox"/> 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 <input type="checkbox"/> Current Carrier <input type="checkbox"/> Previous Carrier <input type="checkbox"/> 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	<input type="checkbox"/> Unlimited Coverage	Amount of Coverage/Aggregate	<input type="checkbox"/> Unlimited Coverage		

State Medical License

In the State of	<input type="checkbox"/> I hold a valid Medical License	<input type="checkbox"/> 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? <input type="checkbox"/> YES <input type="checkbox"/> NO
Board Description			

Additional State Medical License

In the State of	<input type="checkbox"/> I hold a valid Medical License	<input type="checkbox"/> 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? <input type="checkbox"/> YES <input type="checkbox"/> NO
Board Description			

Additional State Medical License

In the State of	<input type="checkbox"/> I hold a valid Medical License	<input type="checkbox"/> 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? <input type="checkbox"/> YES <input type="checkbox"/> 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? <input type="checkbox"/> YES <input type="checkbox"/> NO				
Degree Type? <input type="checkbox"/> AA <input type="checkbox"/> CNM <input type="checkbox"/> CNSA <input type="checkbox"/> CRNA <input type="checkbox"/> CSA <input type="checkbox"/> LPN <input type="checkbox"/> NP <input type="checkbox"/> PA <input type="checkbox"/> RN <input type="checkbox"/> 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? <input type="checkbox"/> YES <input type="checkbox"/> NO				
Degree Type? <input type="checkbox"/> AA <input type="checkbox"/> CNM <input type="checkbox"/> CNSA <input type="checkbox"/> CRNA <input type="checkbox"/> CSA <input type="checkbox"/> LPN <input type="checkbox"/> NP <input type="checkbox"/> PA <input type="checkbox"/> RN <input type="checkbox"/> 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? <input type="checkbox"/> YES <input type="checkbox"/> NO				
Degree Type? <input type="checkbox"/> AA <input type="checkbox"/> CNM <input type="checkbox"/> CNSA <input type="checkbox"/> CRNA <input type="checkbox"/> CSA <input type="checkbox"/> LPN <input type="checkbox"/> NP <input type="checkbox"/> PA <input type="checkbox"/> RN <input type="checkbox"/> 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)	
<input type="checkbox"/> 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? <input type="checkbox"/> YES <input type="checkbox"/> NO		
<input type="checkbox"/> I am not planning to take specialty boards. Please provide a brief explanation.				
<input type="checkbox"/> 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)	
<input type="checkbox"/> 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? <input type="checkbox"/> YES <input type="checkbox"/> NO		
<input type="checkbox"/> I am not planning to take specialty boards. Please provide a brief explanation.				
<input type="checkbox"/> 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)	
<input type="checkbox"/> 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? <input type="checkbox"/> YES <input type="checkbox"/> NO		
<input type="checkbox"/> I am not planning to take specialty boards. Please provide a brief explanation.				
<input type="checkbox"/> 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? <input type="checkbox"/> YES <input type="checkbox"/> 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? <input type="checkbox"/> YES <input type="checkbox"/> 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? <input type="checkbox"/> YES <input type="checkbox"/> NO			
Street Address	Suite/Building	City	State	Zip	Country	

Prescribing Authority

Federal Drug Enforcement Administration (DEA) License

I have State certification <input type="checkbox"/> YES <input type="checkbox"/> NO If Yes, number and dates	Certificate Number	Original Certification Date (MM/DD/YYYY)	Expiration Date (MM/DD/YYYY)
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I am in the process of applying for State certification <input type="checkbox"/> YES <input type="checkbox"/> NO	Please indicate all schedules currently held <input type="checkbox"/> 2 <input type="checkbox"/> 2N <input type="checkbox"/> 3 <input type="checkbox"/> 3N <input type="checkbox"/> 4 <input type="checkbox"/> 5
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Is this certification Limited or Restricted? YES NO If Yes, please explain

State Drug License

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



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)
	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	Audiologist Occupational Therapist Physical Therapist Speech and Language Pathologist	Open	
	Preferred Physician Laboratory (PPL)	Physician in-house labs with CLIA Certification	Open	n/a
	Physician Extender Networks – Licensed	Anesthesia Assistant Nurse Midwife Certified Registered Nurse Anesthetist Nurse Practitioner Physician Assistant	Open	
	Participating Licensed Registered Dietitian	Dietitian	Open	
	ALL Kids Participating – ALL Kids Only	Ophthalmologist Opticians Optometrist	Open	
	Preferred Dentist – Statewide Dental Network	Dentists Oral Surgeons	Open	
	Blue Advantage – Medicare Advantage Program	Medicare Eligible Participating Providers	Open	
	Preferred Sleep Medicine Program	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 <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
------	-------	-----	--------

Mailing Address

City	State	Zip	County
------	-------	-----	--------

Provider Signature	Date
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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 <i>(Required)</i>			
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 <i>(Required)</i>			
DBA (doing business as) if different from above <i>(Optional)</i>			

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 <i>(optional)</i>	
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.