



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 adding a new location must submit this form to have Par Status added to the new location. 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 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	<input type="checkbox"/> Occupational Therapist <input type="checkbox"/> Physical Therapist <input type="checkbox"/> Speech and Language Pathologist	Open	
	Preferred Physician Laboratory (PPL)	Physician in-house labs with CLIA Certification	Open	n/a
	Physician Extender Networks – Licensed	<input type="checkbox"/> Anesthesia Assistant <input type="checkbox"/> Nurse Midwife <input type="checkbox"/> Certified Registered Nurse Anesthetist <input type="checkbox"/> Nurse Practitioner <input type="checkbox"/> Physician Assistant	Open	
	Participating Licensed Registered Dietitian	Dietitian	Open	
	ALL Kids Participating – ALL Kids Only	<input type="checkbox"/> Ophthalmologist <input type="checkbox"/> Opticians <input type="checkbox"/> Optometrist	Open	
	Preferred Dentist – Statewide Dental Network	<input type="checkbox"/> Dentists <input type="checkbox"/> Oral Surgeons	Open	
	Blue Advantage® – Medicare Advantage Program	Medicare Eligible Participating Providers	Open	
	Preferred Sleep Medicine Program	<input type="checkbox"/> In Home Accredited <input type="checkbox"/> 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 BCBSAL 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	
		<input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> – <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>	
Individual NPI <i>(National Provider Identifier)</i>	<input style="width: 100%;" type="text"/>	Organizational NPI	<input style="width: 100%;" type="text"/>
Practice Name		Tax ID Number	
		<input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> – <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>	
E-mail	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 Post Office Box 362142, Birmingham, AL 35236-2142
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