BlueCross BlueShield of Alabama

An Independent Licensee of the Blue Cross and Blue Shield Association

PREFERRED MEDICAL LABORATORY APPLICATION (PML)

Important – Please read the following information before completing the application

This application alone does not entitle or guarantee participation in any Preferred Provider program offered by Blue Cross and Blue Shield of Alabama.

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	☐ Update existing provider information	☐ Add a location	☐ Update existing location	Effective Date of Change

Laboratory Name		
Office Address		
City	State	Zip
Correspondence Address (if different)		
City	State	Zip
Payee/Remit Address		
City	State	Zip
Contact Name		

E-mail	Office Phone	Fax Number
Tax Identification Number (EIN) *(IRS documentation must be attached)*	Alabama Identification Number and CLIA Certification *(Copies must be attached)*	

Type of Business: *(check one)* ☐ Solo ☐ Partnership ☐ Corporation

Name of Owner and/or Officer	Title	Address

List other clinical laboratories in which the owners/officers above have an ownership interest.

Owner	Company Name	Address	EIN/SSN

Additional Required Information

Before mailing, you must include the following information:

- ☐ A copy of Alabama State Board of Health License
- ☐ A completed W-9 form
- ☐ A copy of CLIA Lab certification of compliance
- ☐ A Network Interest Form
- ☐ A copy of an IRS letter identifying your tax name and number OR a copy of a Federal Deposit Coupon, unless tax exempt

Provider Attestation

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 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 amy 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 application and all information will be incorporated by reference, and become part of any Preferred Provider Program Agreement. My signature here authorizes verification of the information I have provided. I understand that failure to submit a complete application with all required documentation during the credentialing process could result in the termination of my preferred status.

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

Blue Cross and Blue Shield Use Only	Provider #_____	Provider #_____	Provider #_____

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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 Dept. 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

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LAB NETWORK INTEREST QUESTIONNAIRE

Please complete in addition to the appropriate application for provider type.

General Information

Entity Name:	
Entity Type: ☐ Lab ☐ Other – *If other please list provider type:*	
Entity National Provider Identifier (NPI):	**Tax Identification Number (EIN):** *(IRS documentation must be attached)*
Are you currently serving Blue Cross and Blue Shield of Alabama members in Alabama? ☐ Yes ☐ No	

What type of services, equipment or supplies are you currently providing or wish to provide for Alabama members? Please list (may attach list):

CPT/HCPCS Code	Description

Are you currently receiving referrals from physicians or other providers in Alabama? If yes, please provide as many examples as possible (may attach list):

Alabama Referring Provider(s) Name	Are you a participating or preferred provider with any other Blue Plans? If so, please list:	Please list all pertinent accreditations:

Completed by	Title	Date Signed

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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.