BlueCross BlueShield of Alabama

An Independent Licensee of the Blue Cross and Blue Shield Association

# PREFERRED PHYSICIAN LABORATORY APPLICATION

☐ Add New Provider ☐ Add a location

## Provider Information

| | | | |
|---|---|---|---|
| Practice Name | | **Type of Business:** *(please check one)* ☐ Solo ☐ Partnership ☐ Corporation | |
| Office Address | City | State | Zip |
| Payment/Remittance Address | City | State | Zip |
| Office Telephone / Fax Number | E-mail | Federal Taxpayer ID Number | |

**Is the lab accredited or certified by Clinical Laboratory Improvement Amendments (CLIA) Program?** ☐ Yes ☐ No

**If yes, what is the level of CLIA certification?** _____

*Please attach verification of certification level. (Moderate to high level certificate required. CLIA certification must be higher than a "Certificate of Waiver".)*

**Is the lab accredited or certified by any federal or state agency?** ☐ Yes ☐ No

**If yes, please check all that apply:** ☐ AABB ☐ AOA ☐ ASHI ☐ CAP ☐ COLA ☐ JCAHO *Please attach a copy of your certification(s).*

| Date of Most Recent CLIA Accreditation | CLIA Certification Number | **Is the lab affiliated with a hospital?** *If yes, please attach an explanation of affiliation.* ☐ Yes ☐ No |
|---|---|---|

## Principle Owner Information *(Attach additional sheets if necessary.)*

| Principle Owners of Lab | Federal Tax ID # | Address | City | State | Zip | Area Code/Phone | Type of Interest |
|---|---|---|---|---|---|---|---|
| | | | | | | | |
| | | | | | | | |

## Please list the physician members in this practice that provide lab services. *(Attach additional sheets if necessary.)*

| | 1. | 2. | 3. | 4. |
|---|---|---|---|---|
| **Provider Name** | | | | |
| **NPI Number** | | | | |

**Does the lab employ a licensed medical laboratory technologist?** ☐ Yes ☐ No *If yes, please attach a copy of the credentials.*

**Who provides the professional interpretation of the lab?**
*Attach additional sheets if necessary.*

## List the names of all personnel actually performing lab services and attach their credentials *(Attach additional sheets if necessary.)*

| 1. | 2. | 3. | 4. |
|---|---|---|---|

**Does this lab perform lab services/tests for any other providers outside the physician practice?** ☐ Yes ☐ No

**If yes, please list provider name and number.** *Attach additional sheets if necessary.*

| | 1. | 2. | 3. | 4. |
|---|---|---|---|---|
| **Provider Name** | | | | |
| **NPI Number** | | | | |

## Please state the make and model number of automated equipment and include names of any manufactured special packaged laboratory kits.

*(Attach additional sheets if necessary.)*

## Please furnish the following information regarding a person we may contact in the event of any questions or additional information needs.

| Contact Name | Office Telephone | E-mail |
|---|---|---|

**** Requires authorized, original signature of the CEO, CFO, President, Provider or Owner.***

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

_____ Signature *(Required)* _____ Title *(Required)* _____ 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
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 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** | ☐ Occupational Therapist ☐ Physical Therapist<br>☐ 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<br>☐ Certified Registered Nurse Anesthetist<br>☐ 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 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 | ___ – _____ |
| Individual NPI *(National Provider Identifier)* | | Organizational NPI | |
| Practice Name | | Tax ID Number | __ – _____ |
| E-mail | Office Phone | Fax Number | |
| **Office Address** | | | |
| City | State | Zip | County |
| **Mailing Address** | | | |
| City | State | Zip | County |
| Provider Signature _____ | | Date _____ | |

## Submission Instructions

| | |
|---|---|
| **Fax**<br>Fax the signed and completed form to: Attn: Credentialing **1-205-220-9545** | **Mail**<br>**Blue Cross and Blue Shield of Alabama,** Attn: Credentialing/Provider Data<br>Post Office Box 362142, Birmingham, AL 35236-2142 |