



PREFERRED PHYSICIAN LABORATORY APPLICATION

Add New Provider Add a location

Provider Information

Practice Name		Type of Business: <i>(please check one)</i> <input type="checkbox"/> Solo <input type="checkbox"/> Partnership <input type="checkbox"/> 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? <i>If yes, please attach an explanation of affiliation.</i> <input type="checkbox"/> Yes <input type="checkbox"/> 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
---	---



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	<input type="checkbox"/> Audiologist <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 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	<input type="text"/> - <input type="text"/>
Individual NPI <i>(National Provider Identifier)</i>	<input type="text"/>	Organizational NPI	<input type="text"/>
Practice Name		Tax ID Number	<input type="text"/> - <input type="text"/>
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
--	---