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 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.

✓	Network	Eligible Provider	Network Status
	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 *(Choose an option to the right.)*	☐ Audiologist ☐ Occupational Therapist ☐ Physical Therapist ☐ Speech and Language Pathologist	Open
	Preferred Physician Laboratory (PPL)	Physician in-house labs with CLIA Certification	Open
	Physician Extender Networks – Licensed *(Choose an option to the right.)*	☐ Anesthesia Assistant ☐ Nurse Midwife ☐ Nurse Practitioner ☐ Certified Registered Nurse Anesthetist ☐ Physician Assistant	Open
	Participating Licensed Registered Dietitian	Dietitian	Open
	ALL Kids Participating – ALL Kids Only *(Choose an option to the right.)*	☐ Ophthalmologist ☐ Opticians ☐ Optometrist	Open
	Preferred Dentist – Statewide Dental Network *(Choose an option to the right.)*	☐ Dentists ☐ Oral Surgeons	Open
	Blue Advantage – Medicare Advantage Program	Medicare Eligible Participating Providers	Open
	Preferred Sleep Medicine Program *(Choose an option to the right.)*	☐ 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 *(National Provider Identifier)*		Organizational NPI	
Practice Name		Tax ID Number	
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