BlueCross BlueShield of Alabama

An Independent Licensee of the Blue Cross and Blue Shield Association

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	☐ Audiologist ☐ Occupational Therapist ☐ Physical Therapist ☐ 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 ☐ Certified Registered Nurse Anesthetist ☐ 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 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

Blue Advantage® is a Medicare-approved PPO Plan provided by Blue Cross and Blue Shield of Alabama, an independent licensee of the Blue Cross and Blue Shield Association.

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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.

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HOSPITAL DATA FORM

This form is for hospital admitting privileges information only.

Provider Information

Provider Name	National Provider Identifier (NPI)	
Address		
City	State	Zip
Phone	Fax Number	E-mail

I hereby attest that: *(Check one please)* ✓

☐ I do not have any **admitting** privileges because my specialty does not admit patients.	Specialty	
☐ I do not have any privileges because I use a hospitalist.	Hospitalist Name	National Provider Identifier (NPI)
☐ I have **admitting** privileges at:	Primary Hospital	
City	State	Zip

Additional Hospitals to which you have admitting privileges may be listed on page 2.

Date my privileges were initially granted at this hospital: *(mm/dd/yyyy)*

Next reappointment/review date to continue my privileges at this hospital is: *(mm/dd/yyyy)*

My level of admitting privileges at this hospital is: *(check one)* ☐ Full ☐ Temporary ☐ Courtesy ☐ None

☐ Applied/Pending Date Applied: *(mm/dd/yyyy)* Expected date of Decision: *(mm/dd/yyyy)*

My current standing at this hospital is: *(check one)* ☐ Good standing with no issues ☐ Restricted ☐ Probationary

If you have any adverse actions from this hospital, including investigations or pending action, please attach a detailed explanation of the situation.

I also hereby grant permission to this hospital to verify and/or release my information including:

1. The effective date my privileges were initially granted at this hospital
2. The upcoming reappointment/review date for continued privileges at this hospital
3. My current standing at this hospital
4. Any adverse actions upon my privileges, including investigations and pending actions, at this hospital.
5. Any other information that may be pertinent to the evaluation process.

I understand this information will be released to the Credentialing Unit for the purpose of properly evaluating me for participation in the Preferred Care Programs.

Requires original signature of the physician.

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

_____ Physician Signature

_____ Date

Submission Instructions

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Mail **Blue Cross and Blue Shield of Alabama,** Attn: Credentialing
Post Office Box 362142, Birmingham, AL 35236-2142

Additional Hospitals to which you have admitting privileges

☐ I have **admitting** privileges at: | Hospital

City | State | Zip

Date my privileges were initially granted at this hospital: *(mm/dd/yyyy)*

Next reappointment/review date to continue my privileges at this hospital is: *(mm/dd/yyyy)*

My level of admitting privileges at this hospital is: *(check one)* ☐ Full ☐ Temporary ☐ Courtesy ☐ None
☐ Applied/Pending Date Applied: *(mm/dd/yyyy)* Expected date of Decision: *(mm/dd/yyyy)*

My current standing at this hospital is: *(check one)* ☐ Good standing with no issues ☐ Restricted ☐ Probationary
If you have any adverse actions from this hospital, including investigations or pending action, please attach a detailed explanation of the situation.

☐ I have **admitting** privileges at: | Hospital

City | State | Zip

Date my privileges were initially granted at this hospital: *(mm/dd/yyyy)*

Next reappointment/review date to continue my privileges at this hospital is: *(mm/dd/yyyy)*

My level of admitting privileges at this hospital is: *(check one)* ☐ Full ☐ Temporary ☐ Courtesy ☐ None
☐ Applied/Pending Date Applied: *(mm/dd/yyyy)* Expected date of Decision: *(mm/dd/yyyy)*

My current standing at this hospital is: *(check one)* ☐ Good standing with no issues ☐ Restricted ☐ Probationary
If you have any adverse actions from this hospital, including investigations or pending action, please attach a detailed explanation of the situation.

☐ I have **admitting** privileges at: | Hospital

City | State | Zip

Date my privileges were initially granted at this hospital: *(mm/dd/yyyy)*

Next reappointment/review date to continue my privileges at this hospital is: *(mm/dd/yyyy)*

My level of admitting privileges at this hospital is: *(check one)* ☐ Full ☐ Temporary ☐ Courtesy ☐ None
☐ Applied/Pending Date Applied: *(mm/dd/yyyy)* Expected date of Decision: *(mm/dd/yyyy)*

My current standing at this hospital is: *(check one)* ☐ Good standing with no issues ☐ Restricted ☐ Probationary
If you have any adverse actions from this hospital, including investigations or pending action, please attach a detailed explanation of the situation.

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ORGANIZATIONAL/PAYEE/ BILLING NPI FORM

It is important that Blue Cross has accurate information about your Individual or Organizational NPI. Providers must notify Blue Cross if this information changes. Blue Cross is unable to use NPIs for billing purposes that have not previously been reported. An accurate NPI is required for additional important purposes including remittance payments, Internal Revenue Service (IRS) reporting, directories and publication mailings.

Fill out form completely. Please print.

Please indicate your Organizational/Payee/Billing NPI information below.

Organizational NPI (National Provider Identifier)		Effective Date
Name		
Address		
City	State	Zip
Office Telephone	Fax Number	
Contact Name	E-mail	
Telephone	Fax Number	

Requires Original Signature of Provider

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

_____ Provider's Signature *(Required)*

_____ Date

Submit a copy of your IRS documentation along with these forms.

☐ Letter 147C ☐ Letter 147T ☐ Letter CP575 ☐ Deposit Coupon

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