BlueCross BlueShield of Alabama

An Independent Licensee of the Blue Cross and Blue Shield Association

Preferred Radiology Credentialing Verification

Blue Cross and Blue Shield of Alabama
Attention: Provider Enrollment and Credentialing
PO Box 362142
Birmingham, AL 35236-2142

INSTRUCTIONS: Please **PRINT** or **TYPE** a response to each question requiring information or a correction. Attach the copies of the documents and any additional information requested. Your response will be used by Health Care Networks and will remain confidential, and can only be released externally with written consent from the Provider. Please understand that these questions are asked of all participants.

I. GENERAL INFORMATION

Type of Facility		Date Completed
Name of Person Completing Form	**Title**	**Phone Number**
		( ) - -

II. FACILITY DEMOGRAPHICS

Facility Name

Location Address (street, city and zip code)	County	Phone Number
		( ) - -
Billing Address (street, city and zip code)	**County**	**Phone Number**
		( ) - -

Name of Facility's Administrator/CEO	Name of Facility's CFO	Federal Tax ID Number
Facility WEB Address (if applicable)		**Facility E-Mail Address**

Is Facility a Subsidiary of a Parent Corporation? ☐ **YES** - Please complete the following ☐ **NO** - Go to the next question

Name of Parent Corporation	Address of Parent Corporation	Tax Status of Parent Corporation

Is Facility Operated under a Management Contract? ☐ **YES** - Please complete the following ☐ **NO** - Go to the next question

Name of Management Company	Address of Management Company

III. FACILITY CREDENTIALING INFORMATION

Is this for a Cone Beam computed tomography? ☐ **YES** ☐ **NO**

Indicate the type of accreditation for each modality, American College of Radiology (ACR), Intersocietal Accreditation Commission (IAC), RadSite, or other national accreditation.

Accreditation	Effective Thru Date	MRI	CT	Nuclear	PET
ACR					
IAC					
RadSite					

IV. ADDITIONAL REQUIRED INFORMATION

Before mailing, you must include the following. Please check off each item as you attach.

- ☐ Facility Accreditation (copy of the certificate or proof of accreditation application)
- ☐ A completed W-9 Form
- ☐ A copy of an IRS LETTER identifying your tax name and number, OR
- ☐ A copy of your FEDERAL DEPOSIT COUPON (unless tax exempt)
- ☐ If tax exempt, a copy of your CERTIFICATION OF EXEMPTION must be attached.

V. FINANCIAL (Full Disclosure is Required)

- ☐ List physicians providing services at this facility with their respective Blue Cross and Blue Shield of Alabama provider number. Please identify the financial interest to the facility of these physicians who provide services.
- ☐ List physicians who have referred patients for services within the last 12 months to this facility that have financial interest in this facility along with the Unique Provider Identification Number (UPIN) for each.

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

Name		
Phone Number (␣␣␣)-␣␣␣-␣␣␣␣	Fax Number (␣␣␣)-␣␣␣-␣␣␣␣	Email Address

VI. FACILITY CERTIFICATION SECTION—Please keep a copy of this survey and all attachments for your records.

I have read the contents of this survey and all attached documents and used reasonable care in determining the truth fullness, correctness and completeness of all information in this application before signing below. If I become aware that any information in this survey is not true, correct, or complete, I agree to notify Blue Cross of any changes in this information within 45 days of the effective date of the change. I authorize Blue Cross to collect any information necessary to verify the information in this survey. I understand that this survey alone does not entitle or guarantee participation in any 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, this survey and all information will be incorporated by reference, and become part of any Preferred Provider Agreement. My signature hereby authorizes verification of the information I have provided.

Completed By:

Printed Name and Title	Signature
(␣␣␣)-␣␣␣-␣␣␣␣ Phone Number	Date

Mail completed credentialing form and supporting documents to:

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