BlueCross BlueShield of Alabama

An Independent Licensee of the Blue Cross and Blue Shield Association

CONFIDENTIAL RECREDENTIALING VERIFICATION FORM

INSTRUCTIONS: Please PRINT or TYPE a response to each question below. Please attach copies of all required documents indicated in Section X. Information submitted will remain confidential.

I. General Information

Practitioner's Name (first/middle/last)			Preferred Name	
Title	Social Security Number	**Gender:** ☐ Male ☐ Female		Date of Birth
Race and Ethnicity	National Provider Identifier (NPI)	ECFMG Number (if applicable)		ECFMG Issue Date
Federal DEA Number				Federal DEA Expiration Date
Primary Office Address	City	State		Zip
Practitioner E-mail Address	Office Telephone	Fax Number		

II. License Information (For the following state licensing information, write the name of the state in the top block.)

State Name				
Date orginally licensed				
State License Number				
State Medicare Provider Number				
State Medicaid Provider Number				

III. Practice Specialty

	Primary	Secondary
Specialty Name		
Board Certified? (Yes or No)		
Name of Board (if applicable)		
Certification Number		

IV. Professional Liability – Please list your Insurance Carrier (Domestic Insurer Only)

Name of professional Liability carrier	OfficeTelephone

V. Medical Education/Work History (Please update your work and education history since last credentialed and include it with the requested documents.)

Date Ranges (MM/YYYY – MM/YYYY)	**Name of Employer/School**	**City & State of Employer/School**	**Activity(ies)**

VI. Collaborating/Supervising Practitioner – *if Applicable* (required for Nurse Practitioners and Physician Assistants)

NPI	**Name of Collaborating/Supervising Physican**	**Effective Date of Collaboration** (MM/DD/YY)

VII. Hospital Admitting Privileges (List hospitals where you currently have admitting privileges.) *If you have any adverse actions from any of these hospitals, including investigations or pending actions, please attach a detailed explanation of the situation(s), if applicable.*

City	State	Hospital Name and Hospital NPI	Conditions of Admitting Privileges	Effective Date of Privileges (MM/DD/YYYY)	Primary	Current Status
		Name: --- NPI:	☐ Full ☐ Temporary ☐ Courtesy ☐ Applied/Pending ☐ None		☐ Yes ☐ No	☐ Good Standing ☐ Restricted ☐ Probation ☐ Suspended ☐ Terminated, effective: _____
		Name: --- NPI:	☐ Full ☐ Temporary ☐ Courtesy ☐ Applied/Pending ☐ None		☐ Yes ☐ No	☐ Good Standing ☐ Restricted ☐ Probation ☐ Suspended ☐ Terminated, effective: _____

VIII. Financial

Do you have a financial interest or service contract with any other healthcare entity, including but not limited to laboratories, diagnostic facilities, hospitals or home health agencies?

☐ Yes – *Please complete the following.* ☐ No – *Go to next section.*

Company Name	Principal	Federal Tax ID Number	Address/City/State/Zip	Phone	Type of Interest

IX. Q & A (If you answer YES to any of the following questions # 1- #14, please include a detailed explanation of each situation.

Since you were last credentialed:

1. Have you been convicted of a felony which was not overturned on appeal? ☐ Yes ☐ No
2. Have you been subject to any disciplinary action, including conditions, restrictions, letters of concern, etc., from:
   a. Any State Licensure Board ☐ Yes ☐ No
   b. Any Medical Society ☐ Yes ☐ No
   c. Any Peer Review Organization ☐ Yes ☐ No
   d. Hospital Medical Staff *(except failure to complete medical records)* ☐ Yes ☐ No
3. Have you had any restrictions or conditions of prescribing privileges (even if voluntary) ☐ Yes ☐ No
4. Have you had any restrictions or conditions on your license/practice privileges due to substance abuse (even if voluntary)? ☐ Yes ☐ No
5. Do you have any physical, mental, or substance abuse problems that impede your ability to perform according to generally accepted standards of professional performance or that pose a threat to the health and safety of your patients? ☐ Yes ☐ No
6. Have you been expelled or suspended from receiving Medicare or Medicaid payments? ☐ Yes ☐ No
7. Have you been expelled from a physician network, HMO, etc.? ☐ Yes ☐ No
8. Have you been restricted, suspended from, or denied privileges by any hospital? ☐ Yes ☐ No
9. Have you voluntarily relinquished hospital privileges for any reason other than physical relocation (more than 50 miles)? ☐ Yes ☐ No
10. Do you now or have you had a surcharge from your liability carrier (If yes, amount: $_____) ☐ Yes ☐ No
11. Have you had a judgment against you or a settlement in a professional liability case (including out-of-pocket payments)? ☐ Yes ☐ No
12. Do you currently have litigation pending against you? ☐ Yes ☐ No
13. Do you currently owe Medicare or Blue Cross and Blue Shield an outstanding balance? (If yes, amount: $_____) ☐ Yes ☐ No
14. Has there been a gap of six months or more in your work history, other than continued education? ☐ Yes ☐ No
15. Do you currently use an electronic practice management vendor? ☐ Yes ☐ No

X. Additional Information Required (Before sending, you must include the following. Please ✓ off each item as you attach.)

☐	A copy of your current domestic professional liability certificate from your insurance company, including your name, expiration date, and coverage limits
☐	A detailed, written explanation for any YES answers on questions 1-14 in Section IX above.
☐	A completed hospital data form if information is not included, if applicable.
☐	A complete work & education history for the past 3 years if information is not included (months and years)

Please furnish the following information regarding a person we may contact in the event we need any additional information.

Contact's Name (first/middle/last)	Preferred Name	
Office E-mail Address	Office Telephone	Fax Number

XI. Practitioner Certification Section (Please keep a copy of this survey and all related documentation for your records.)

I understand and agree that I, the practitioner, am solely responsible for all information submitted with this recredentialing verification ("survey" or "application"). I have read the contents of this survey and the information contained herein and all documents are true, correct, and complete to the best of my knowledge. I have used reasonable care in determining the truthfulness, correctness, and completeness of all information in this application before signing below. If I become aware of any information in this application that is not true, correct, or complete, I agree to immediately notify Blue Cross and Blue Shield of Alabama. I understand that willful falsification or willful omission of any information, as well as not returning this survey and all requested documentation, could result in termination of my preferred status. I understand that this application does not entitle or guarantee participation in any Preferred Provider Program offered by Blue Cross and Blue Shield of Alabama. I am familiar with and agree to abide by the Blue Shield programs that apply to my provider type. I agree that any existing or future overpayment to me by Blue Shield may be recouped by Blue Shield through future payments. I understand that my name and specialty may be listed in directories published by Blue Cross and Blue Shield of Alabama at its discretion, but without obligation to do so. In the event I am selected to participate in any Preferred Provider Program offered by Blue Cross and Blue Shield of Alabama, this survey and all included documentation will be incorporated by reference and become part of any Preferred Provider Agreement. My signature below authorizes verification of the information which I have provided herein and certifies that this information is true, correct, and complete to the best of my knowledge.

I certify this informationis complete and correct to the best of my knowledge.			
	Printed Name of Practitioner	Practitioner's Handwritten Signature	Date Signed

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

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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

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

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.*		