



# HEALTHCARE FACILITY APPLICATION

**Completed form with supporting documents may be returned by fax or mail to:**

**Fax** Attn: Facility Credentialing **1-205-220-9545**

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

**Email** **credcross@bcbsal.org**  
with any questions.

**Facility Type\*** (Choose one facility type below for the enrolling facility and list subparts in Facility Subpart section.)

A separate application will be required for each facility type with separate billing information including separate billing NPI.

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Acute Care Hospital           | <input type="checkbox"/> Skilled Nursing Facility                 | <input type="checkbox"/> Ambulatory Surgery Center       |
| <input type="checkbox"/> Long Term Acute Care Hospital | <input type="checkbox"/> Dialysis Center                          | <input type="checkbox"/> Single Specialty Surgery Center |
| <input type="checkbox"/> Rehabilitation Hospital       | <input type="checkbox"/> Residential Treatment Facility           | <input type="checkbox"/> Ophthalmology                   |
| <input type="checkbox"/> Mental Health Inpatient       | <input type="checkbox"/> Rural Health Clinic (RHC)                | <input type="checkbox"/> Plastic Surgery                 |
| <input type="checkbox"/> Veterans/Military Hospital    | <input type="checkbox"/> Federally Qualified Health Center (FQHC) | <input type="checkbox"/> Other                           |

**Fields denoted with an asterisk\* must be completed.**

## General Facility Information

Facility Name*		Are you incorporated?* <input type="checkbox"/> Yes <input type="checkbox"/> No
Payment Tax ID/EIN Number*	Organizational Billing NPI Number*	Medicare Number*
Total Number of Beds?	Specify number of each:	Hospitals LTAC Rehabilitation Facilities
License*	Issue Date*	Expiration Date*
Accreditation* (Attach copy of most recent approval)	Issue Date*	Expiration Date*
Contact Name*	Contact Email*	
Contact Phone Number*	Contact Fax Number*	

## Facility Location Information (Must have a street address – PO Boxes are not acceptable.)

Street Address*		
City*	State*	Zip*
Main Switchboard Phone Number*	Main Fax Number*	

## Correspondence Address (For notifications, newsletters, etc.)

Correspondence Address*		
City*	State*	Zip*
Correspondence Email*	Correspondence Phone Number*	Correspondence Fax Number*

## Payment Address (If different from location and correspondence address.)

Payment Name*		
Payment Address*		
City*	State*	Zip*
Payment Contact Email*	Payment Phone Number*	Payment Fax Number*

Facility Subparts		
For facilities that include subparts, please check all that apply (all units included under Tax ID/billing NPI of facility and not billing separately). If the operation or management of any subpart is contracted to another entity, please list entity to the right.		
Subpart	Name of Entity/DBA	Subpart NPI if Available
<input type="checkbox"/> Psychiatric Unit		
<input type="checkbox"/> Rehabilitation Unit		
<input type="checkbox"/> Swing Bed Unit		
Residential Treatment Facility (Only)		
<input type="checkbox"/> Adult		
<input type="checkbox"/> Adolescent		
<input type="checkbox"/> Geriatric		
Ownership and/or Control*		
Is the Management vested in the board?		
Chief Executive Officer (CEO) Name	Phone Number	
Chief Financial Officer (CFO) Name	Phone Number	
Full-time Medical Director Name*	Phone Number*	
Medical Director Name*	Phone Number*	
Liability Insurance*		
<b>Professional liability insurance</b> , including coverage for any medical negligence or malpractice, in the minimum amounts of \$1,000,000 per occurrence and \$1,000,000 in the aggregate per calendar year. (Please note <b>general liability</b> coverage will not satisfy this requirement.)		
<b>General liability insurance</b> or comprehensive public liability insurance, including coverage for accidents or other incidents causing injury to any person or property and occurring on or about the premises of Facility in the minimum amount of \$200,000 per person per occurrence and \$600,000 per occurrence per calendar year.		
Requires authorized signature of the CEO or CFO.		
I certify this information is complete and correct to the best of my knowledge.           Print Name _____ Title _____           Signature _____ Date _____		



**BlueCross BlueShield  
of Alabama**

An Independent Licensee of the Blue Cross and Blue Shield Association

## FACILITY BUSINESS 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.

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
	<b>Participating Ground Ambulance/All Kids/Blue Advantage®</b>	Ground Ambulance	Open
	<b>Participating Air Ambulance/Blue Advantage</b>	Air Ambulance	Open
	<b>Participating Ambulatory Surgery Center</b>	Multi-Specialty	Open
	<b>Preferred Single Specialty Ambulatory Surgery Center</b>	Dermatology    Eye    Gastroenterology    Plastic Surgery	Open
	<b>Participating Dialysis</b>	Dialysis	Open
	<b>Preferred Medical Laboratory (PML)</b>	Clinical Labs with CLIA Certification	Open
	<b>Participating Residential Treatment Facility</b>	Certified by the Alabama Department of Mental Health	Open
	<b>Blue Advantage – Medicare Advantage Program</b>	ASC Home Health Mental Health Portable Image SNF-Pharmacy Infusion DME IDTF Pharmacy Rural Health ESRD Laboratory	Open
	<b>Preferred Home Health Agency</b>	Home Health Agency	Open
	<b>Preferred Home Infusion Agency</b>	Home Infusion Agency	Open
	<b>Preferred Durable Medical Equipment (DME)</b>	DME Supplier with physical facility within Alabama	Open
	<b>Preferred Hospice Network</b>	Hospice agency with AL Dept. of Health Certificate	Open
	<b>NO – I am not interested in participating in any Blue Cross network.</b>		

### 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.

### Name of Facility/Business

DBA		Organizational NPI	
Contact Name		Tax ID Number	
Email	Office Phone		Fax Number

### Location Address

City	State	Zip	County
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### Mailing Address

City	State	Zip	County
Signature	Title		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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**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
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**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**

<b>Signature</b>	<b>Date</b>
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Telephone	Fax	E-mail <i>(optional)</i>
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**Tax Address**

City	State	Zip	County
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**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.