



Important – Please read the following information before completing the application

This application alone does not entitle or guarantee participation in any Preferred Provider program offered by Blue Cross and Blue Shield of Alabama.

Instructions: Please PRINT or TYPE a response for each question. Please attach the copies of the documents and any additional information requested. Your responses will be used by the Credentialing Committee and will remain confidential. Please understand that these questions are asked of all participants.

<input type="checkbox"/> Add New Provider	<input type="checkbox"/> Add a location
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I. General Information

PROVIDER'S LAST NAME	SUFFIX	FIRST NAME	MIDDLE INITIAL	Preferred Name	Professional Title
Social Security Number	National Provider Identifier (NPI)		Languages you speak fluently: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> French <input type="checkbox"/> German <input type="checkbox"/> Other		Race and Ethnicity
Date of Birth	County of Birth	State of Birth		Country <input type="checkbox"/> United States <input type="checkbox"/> _____	Gender: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
Are you a U.S. citizen? <input type="checkbox"/> YES <input type="checkbox"/> NO		Legal right to work in the U.S.? <input type="checkbox"/> YES <input type="checkbox"/> NO		Email Address	

A. Medical Education (Attach additional sheets if necessary)

School Name	Dates attended; please include month/years Begin Date: (MM/YYYY) Ended: (MM/YYYY)		Degree Awarded
Street Address	City	State	Zip
Country			

B. Postgraduate Education Training: Internship (Attach additional sheets if necessary)

Institution Name	Dates attended; please include month/years Begin Date: (MM/YYYY) Ended: (MM/YYYY)		Degree Awarded
Street Address	City	State	Zip
Country			

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

Name of the state licensed	1. _____	2. _____	3. _____	4. _____
State license number				
Licensing board				
Date originally licensed				
License expiration date				

III. Financial

Do you have a financial interest or service contract with any other health care entity, including but not limited to laboratories, diagnostic facilities, hospitals or home health agencies? YES - *Please complete the following.* NO - *Go to next question.*

1. Company Name	2. Principles	Federal Tax ID #	Address	City	State	Zip	Area Code/Phone	Type of Interest
1.								
2.								
1.								
2.								

Will you be using a billing agency? YES - Attach a copy of the signed contractual agreement with your billing agency and complete the remainder of this section. NO - Section VIII.

Name of Billing Agency	Employer ID Number	Contact Person
Street Address	City	State
	Zip	County
Telephone Number (include area code)	Fax Number (include area code)	Email Address

Is your practice owned by a Managed Care Organization? (i.e., Phycor, MedPartners, etc.) YES NO
If yes, name of organization:

IV. Practice Location Information (If you practice at additional locations, please provide information on a separate sheet. If applying for the PMD network, please refer to the Primary and Practicing Specialty Information sheet for determination of eligible specialties.)

	Primary Practice Location	Secondary Practice Location	Third Practice Location
Contact Person			
Practice Name (DBA)			
Practice Address – Street			
Practice Address – City, State, Zip			
Office Telephone (include area code)			
Appointment Telephone (include area code)			
Office Fax Number (include area code)			
Primary Specialty at this Location			
Primary Specialty at this Location (if different from your primary specialty)			
Date of Employment at this Location			
Taxpayer Name			
Federal Taxpayer ID Number			
Payee/Remittance NPI			
Legal Business Name (Payee)			
Payment/Remittance Address – Street			
Pmt/Remit Address – City, State, Zip			
Pmt/Remit Phone (include area code)			
Pmt/Remit Fax (include area code)			
Correspondence Address – Street			
Correspondence Address – City, State, Zip			
Office E-mail Address			
Are you accepting new patients?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
	<input type="checkbox"/> Accepting all (or check all that apply) <input type="checkbox"/> Blue Cross <input type="checkbox"/> Blue Advantage <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid	<input type="checkbox"/> Accepting all (or check all that apply) <input type="checkbox"/> Blue Cross <input type="checkbox"/> Blue Advantage <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid	<input type="checkbox"/> Accepting all (or check all that apply) <input type="checkbox"/> Blue Cross <input type="checkbox"/> Blue Advantage <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid
Is this location address the same as your residence?	<input type="checkbox"/> YES - Attach copy of Business License and Zoning Permit <input type="checkbox"/> NO	<input type="checkbox"/> YES - Attach copy of Business License and Zoning Permit <input type="checkbox"/> NO	<input type="checkbox"/> YES - Attach copy of Business License and Zoning Permit <input type="checkbox"/> NO
Does this location meet the Americans with Disabilities Act (ADA) standards?	<input type="checkbox"/> YES If yes, check all that apply: <input type="checkbox"/> NO <input type="checkbox"/> Equipment <input type="checkbox"/> Office <input type="checkbox"/> Exam Room <input type="checkbox"/> Parking	<input type="checkbox"/> YES If yes, check all that apply: <input type="checkbox"/> NO <input type="checkbox"/> Equipment <input type="checkbox"/> Office <input type="checkbox"/> Exam Room <input type="checkbox"/> Parking	<input type="checkbox"/> YES If yes, check all that apply: <input type="checkbox"/> NO <input type="checkbox"/> Equipment <input type="checkbox"/> Office <input type="checkbox"/> Exam Room <input type="checkbox"/> Parking
Foreign Language Spoke by Staff	<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Sign <input type="checkbox"/> French <input type="checkbox"/> German <input type="checkbox"/> Other	<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Sign <input type="checkbox"/> French <input type="checkbox"/> German <input type="checkbox"/> Other	<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Sign <input type="checkbox"/> French <input type="checkbox"/> German <input type="checkbox"/> Other
TDD Available	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Which income reporting form do you receive from your employer or the Internal Revenue Service at the end of the calendar year?	<input type="checkbox"/> 1099 - Attach copy of Employment Contract <input type="checkbox"/> W-2 <input type="checkbox"/> 1065-K1	<input type="checkbox"/> 1099 - Attach copy of Employment Contract <input type="checkbox"/> W-2 <input type="checkbox"/> 1065-K1	<input type="checkbox"/> 1099 - Attach copy of Employment Contract <input type="checkbox"/> W-2 <input type="checkbox"/> 1065-K1
Is this location a nursing home?	<input type="checkbox"/> YES: Name _____ Tax ID# _____ <input type="checkbox"/> NO	<input type="checkbox"/> YES: Name _____ Tax ID# _____ <input type="checkbox"/> NO	<input type="checkbox"/> YES: Name _____ Tax ID# _____ <input type="checkbox"/> NO
Is this location a hospital?	<input type="checkbox"/> YES: Name _____ Tax ID# _____ <input type="checkbox"/> NO	<input type="checkbox"/> YES: Name _____ Tax ID# _____ <input type="checkbox"/> NO	<input type="checkbox"/> YES: Name _____ Tax ID# _____ <input type="checkbox"/> NO
In which setting will services be rendered?			

How many patients do you see at your **office** on an average day?

How many patients do you see at the **hospital** on an average day?

V. Primary Practice Information

Daily Office hours	Sunday	Monday	Tuesday	Holidays Your Office Closes
	<input type="checkbox"/> AM <input type="checkbox"/> PM <input type="checkbox"/> PM <input type="checkbox"/> PM	<input type="checkbox"/> AM <input type="checkbox"/> PM <input type="checkbox"/> PM <input type="checkbox"/> PM	<input type="checkbox"/> AM <input type="checkbox"/> PM <input type="checkbox"/> PM <input type="checkbox"/> PM	
Wednesday <input type="checkbox"/> AM <input type="checkbox"/> PM <input type="checkbox"/> PM <input type="checkbox"/> PM	Thursday <input type="checkbox"/> AM <input type="checkbox"/> PM <input type="checkbox"/> PM <input type="checkbox"/> PM	Friday <input type="checkbox"/> AM <input type="checkbox"/> PM <input type="checkbox"/> PM <input type="checkbox"/> PM	Saturday <input type="checkbox"/> AM <input type="checkbox"/> PM <input type="checkbox"/> PM <input type="checkbox"/> PM	<input type="checkbox"/> New Year's Day <input type="checkbox"/> Good Friday <input type="checkbox"/> Memorial Day <input type="checkbox"/> Independence Day <input type="checkbox"/> Labor Day <input type="checkbox"/> Thanksgiving <input type="checkbox"/> Christmas Day <input type="checkbox"/> Other

VI. Malpractice Information

Name of professional liability carrier	Length of time with current carrier	Professional liability insurance aggregate	Professional liability per case
		\$	\$

VII. Other Practice Affiliations Examples include HMOs, IPAs, PPOs, etc.

Institution or Organization	Affiliation	Address	City	State	Zip	Area Code/Phone	Area Code/Fax

VIII. Professional Memberships

Organization Name	Member Since (MM/DD/YYYY)	Any Offices Held (include dates)

IX. Question & Answer

If the answer to any of the following questions #1 – #14 is “Yes,” please attach a detailed explanation of each situation.

1. Have you ever been convicted of a felony, which was not overturned on appeal?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
2. Have you been subject to any disciplinary action from:	<input type="checkbox"/> YES	<input type="checkbox"/> NO
a. State Licensure Board	<input type="checkbox"/> YES	<input type="checkbox"/> NO
b. Any professional organization	<input type="checkbox"/> YES	<input type="checkbox"/> NO
c. Medicare or Medicaid	<input type="checkbox"/> YES	<input type="checkbox"/> NO
3. Have you ever had any restrictions placed on your license or practice privileges due to disciplinary action for abuse of drugs or alcohol?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
4. Have you ever been expelled or suspended from receiving Medicare or Medicaid payments?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
5. Have you ever been expelled from a provider network?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
6. Have you ever been restricted or suspended from or denied privileges by any hospital not listed in Section VI on Page 3 of this application?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
7. Have you ever voluntarily relinquished privileges?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
8. Do you now or have you ever had a surcharge from your liability carrier? <i>(If yes, specify amount of surcharge)</i>	<input type="checkbox"/> YES	<input type="checkbox"/> NO
9. Have you ever had a judgment against you or a settlement in a professional liability case?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
10. Do you currently have litigation pending against you involving your practice?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
11. Do you currently owe Medicare or Blue Cross and Blue Shield an outstanding balance?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
12. Do you have any physical, mental, or substance abuse problems that would impede your ability to perform according to accepted standards of professional performance or pose a threat to the health and safety of patients?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
13. Has there ever been a gap of six months or more in your work history? <i>If yes, please provide detailed explanation:</i>	<input type="checkbox"/> YES	<input type="checkbox"/> NO
14. Do you utilize clinical pathways in your office practice?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
15. Is your office medical documentation generally: <input type="checkbox"/> Handwritten <input type="checkbox"/> Transcribed		
16. Do you currently use an electronic practice management vendor? <i>If yes, please name the Vendor:</i>	<input type="checkbox"/> YES	<input type="checkbox"/> NO
17. Are you a Medicare Participating Provider?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
18. Do you currently utilize P.T.A.s, P.T. Technicians, O.T.A.s, OT Technicians, Massage Therapists, Athletic Trainers or Exercise Physiologists? <i>If yes, please provide name, license number and Professional designation:</i>	<input type="checkbox"/> YES	<input type="checkbox"/> NO
19. Are you a certified Hand Therapist?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
20. Do you provide: <i>(Check all that apply)</i> <input type="checkbox"/> PT <input type="checkbox"/> OT <input type="checkbox"/> Speech <input type="checkbox"/> Orthotics <input type="checkbox"/> Braces <input type="checkbox"/> Other		



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 <i>(Choose an option to the right.)</i>	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 <i>(Choose an option to the right.)</i>	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 <i>(Choose an option to the right.)</i>	Ophthalmologist Opticians Optometrist	Open
	Preferred Dentist – Statewide Dental Network <i>(Choose an option to the right.)</i>	Dentists Oral Surgeons	Open
	Blue Advantage – Medicare Advantage Program	Medicare Eligible Participating Providers	Open
	Preferred Sleep Medicine Program <i>(Choose an option to the right.)</i>	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 <i>(National Provider Identifier)</i>		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	



**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 <i>(Required)</i>			
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 <i>(Required)</i>			
DBA (doing business as) if different from above <i>(Optional)</i>			

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 <i>(optional)</i>	
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.