Alabama Uniform Provider Application

Instructions

If applying for a provider number with Blue Cross Blue Shield of Alabama, Blue Cross needs the following information completed and returned to us by mail or fax. This information is needed in order for your provider number to be assigned and your application to be processed

- Alabama Uniform Provider Application

These forms may be downloaded from http://www.bcbsal.com/uniprovapp/pdf/bluecrossupaforms.pdf

- A Tax Payer Identification Number Request – W9 for each tax number.
- Hospital Affiliation Data for each hospital that you are currently affiliated with.
- A Blue Cross and Blue Shield of Alabama Network Interest Form must be submitted for participation in certain network programs.
- Electronic Funds Transfer (EFT) Authorization Agreement.

The following additional information must also be returned:

1) Notification of Board Certification or Board Eligibility, or if a resident or recent resident, a Residency Certificate and Medical Degree and Internship Certificate.

2) Copy of ECFMG or 5th Pathway Certificate if foreign graduate.

3) Current Professional Liability Insurance Certificate (Domestic Insurer Only).

4) Copy of IRS documentation (i.e. Letter 147T or 147C, Federal Deposit Coupon, ETPS, or Letter CP575).

5) If you want to be a Preferred Radiologist and you are certified, you must send a copy of your MRI, PET and CT ACR Certificates.

6) A *Blue Cross and Blue Shield of Alabama Network Interest Form* must be submitted for participation in certain network programs (Blue Advantage, Nurse Practitioner/Mid-Wife, Participating Chiropractor, Certified Registered Nurse Anesthetist, etc.). See Contract Form for list of additional network programs.

7) Electronic Funds Transfer (EFT) Authorization Agreement - Enrollment form to set up direct deposit of payments.

All required documentation should be mailed to:

Blue Cross and Blue Shield of Alabama
Attention: Provider Enrollment and Credentialing
P.O. Box 362142
Birmingham, Alabama 35236-2142

The required information may also be faxed to (205) 220-9545.

Once the requested information has been received, Blue Cross can complete the processing of your application. Failure to send the required information may delay the processing of your application. Please include your Application Control Number on all correspondence. Additional questions about your Blue Cross application can be directed to (205) 220-6765

Thank You

Alabama Uniform Provider Application

Practitioner Information

Social Security Number

First Name* | Middle Name | Last Name* | Suffix

Preferred Name | Gender

If your professional license has ever been issued under a name other than the name listed above (e.g. maiden name, alias, nicknames) please indicate below:

First Name | Middle Name | Last Name | Suffix

Birth Date (mm/dd/yyyy)*

Did you complete your medical school or medical training in a foreign country?* ☐ Yes ☐ No

If Yes, please provide your ECFMG Certificate Number

Practitioner E-Mail Address

Degree Type*

☐ AA	☐ Clinic	☐ CNM	☐ CNS	☐ CRNA	☐ CSA
☐ CST	☐ CSW	☐ DC	☐ DDS	☐ DDS MD	☐ DMD
☐ DMD MD	☐ DMIN	☐ DO	☐ DPM	☐ EDD	☐ LCSW
☐ LD	☐ LMFT	☐ LP	☐ LPC	☐ LPN	☐ MA
☐ MD	☐ MD DDS	☐ MD DMD	☐ MD PHD	☐ MS	☐ NP
☐ OD	☐ OTR	☐ PA	☐ PHD	☐ PHD MD	☐ PSY D
☐ RD	☐ RN	☐ RPT	☐ Other: _____		

Are you fluent in any languages other than English?

☐ Spanish	☐ French	☐ German	☐ Italian
☐ Arabic	☐ Chinese	☐ Japanese	

Other language not listed: _____

US Citizen* ☐ Yes ☐ No - If No, Alien Registration Number

Country of Birth*

Legal Right to Work in U.S.?* ☐ Yes ☐ No

County of Birth* | State of Birth

Do you have physician coverage for your patients 24 hours per day, seven days per week?* ☐ Yes ☐ No

Do you or any member of your family own, have an investment in, or otherwise have a business interest in any clinical laboratory, diagnostic or testing center, hospital surgicenter, ambulatory surgical center, or other business dealing with the provision of ancillary health services, equipment or supplies? * ☐ Yes ☐ No

Do you have any professional practice history or military experience (other than hospital affiliations), from graduate school to present? ☐ Yes ☐ No

NPI* | NPI Effective Date*

* Indicates Required Field

Alabama Uniform Provider Application

Practice Information

Legal Practice Name*

Tax ID*

Tax ID Start Date

DBA

Office Effective Date*

If this location is a hospital, please specify name

Street Address*

Suite/Building

City*

State*

ZIP*

County*

Do you accept Medicare patients? ☐ Yes ☐ No AL Medicare # AL Medicaid #

Office Telephone Number*

( )

Appointment Telephone Number*

( )

Office Fax Number

( )

Is a Telephone Device for the Deaf (TDD) Available?* ☐ No ☐ Yes – TDD Telephone Number (_____) _____

Office E-Mail Address

Office Manager

Title

First Name

Last Name

Suffix

Primary Practicing Specialty*

Secondary Practicing Specialty

Languages spoken by staff in addition to English: ☐ Spanish ☐ French ☐ German ☐ Italian ☐ Arabic ☐ Chinese ☐ Japanese ☐ Other: _____

Handicap Access? * ☐ Yes ☐ No

Are you accepting new patients? * ☐ Yes ☐ No ☐ Not Applicable

Office Practice Type* ☐ Individual ☐ Group

Is this location an Urgicenter, After Hours or Urgicare Clinic?* ☐ Yes ☐ No

Physician Type ☐ Primary Care Physician ☐ Specialist

Will you be providing Emergency Room Services? ☐ Yes ☐ No

Are there age limitations on your patients?* ☐ No ☐ Yes – Please specify from _____ years to _____ years

CLIA Certificate Number

CLIA Expiration Date (mm/dd/yyyy)

CLIA Waiver ☐ Yes ☐ No

• Indicates Required Field

Alabama Uniform Provider Application

Practice Information

Do you perform surgery in your office?* ☐ Yes ☐ No

Is this your primary location?* ☐ Yes ☐ No

Is your location a residence?* ☐ Yes ☐ No

If residence, please provide

Business License Number _____ Zoning Permit Number _____

Office Hours*

	Monday		Tuesday		Wednesday	
	From	To	From	To	From	To

	Thursday		Friday		Saturday		Sunday	
	From	To	From	To	From	To	From	To

Holidays your office closes*

☐ New Year's Day ☐ Good Friday ☐ Memorial Day ☐ Independence Day ☐ Labor Day

☐ Thanksgiving ☐ Christmas Day ☐ Other, please specify: _____

Correspondence Address ☐ Is this address the same as the office practice address?

Street Address _____ Suite/Building _____

City _____ State _____ ZIP _____

Telephone Number ( ) Fax Number ( )

Payee/Remittance Address ☐ Is this address the same as the office practice address?

Billing NPI _____ Billing NPI Effective Date _____

Is this a billing agency? * ☐ No ☐ Yes – If yes, Name: _____

Street Address* _____ Suite/Building _____

City* _____ State* _____ ZIP* _____

Office Telephone Number* ( ) Office Fax Number ( )

Office E-Mail Address: _____

• Indicates Required Field

Alabama Uniform Provider Application

Covering Physicians

Your covering physicians should agree to the same fees and follow the same administrative procedures.

First Name* | Middle Name | Last Name* | Suffix

NPI* | Telephone Number*

Specialty*

First Name* | Middle Name | Last Name* | Suffix

NPI* | Telephone Number*

Specialty*

First Name* | Middle Name | Last Name* | Suffix

NPI* | Telephone Number*

Specialty*

First Name* | Middle Name | Last Name* | Suffix

NPI* | Telephone Number*

Specialty*

Make additional copies of this page as necessary

*Indicates Required Field

Alabama Uniform Provider Application

Physician Extenders

Please enter your Physician Extenders

First Name* | Last Name* | Suffix

Specialty*
☐ CRNA ☐ Nurse/Midwife ☐ Physician Assistant
☐ Nurse Practitioner ☐ Surgical Assistant ☐ Other: _______________

NPI*

First Name* | Last Name* | Suffix

Specialty*
☐ CRNA ☐ Nurse/Midwife ☐ Physician Assistant
☐ Nurse Practitioner ☐ Surgical Assistant ☐ Other: _______________

NPI*

First Name* | Last Name* | Suffix

Specialty*
☐ CRNA ☐ Nurse/Midwife ☐ Physician Assistant
☐ Nurse Practitioner ☐ Surgical Assistant ☐ Other: _______________

NPI*

First Name* | Last Name* | Suffix

Specialty*
☐ CRNA ☐ Nurse/Midwife ☐ Physician Assistant
☐ Nurse Practitioner ☐ Surgical Assistant ☐ Other: _______________

NPI*

Make additional copies of this page as necessary

*Indicates Required Field

Alabama Uniform Provider Application

Conflict of Interest

If you or any member of your family own, have an investment in, or otherwise have a business interest in any clinical laboratory, diagnostic or testing center, hospital surgicenter, ambulatory surgical center, or other business dealing with the provision of ancillary health services, equipment or supplies, you must list it here.

Name of Business*

Business Type*

☐ Ambulatory Surgical Center ☐ Clinical Laboratory ☐ Diagnostic/Testing Center
☐ Hospital Surgicenter ☐ Other: _____

Nature of Business*

☐ Investor ☐ Owner ☐ Partner
☐ Sole Proprietor ☐ Other: _____

Street Address*

Suite/Building

City*

State*

ZIP*

Telephone Number* ( )

Tax ID Number*

*Indicates Required Field

Alabama Uniform Provider Application

State Medical License

State Medical License

In the State of *

☐ I am in the process of applying for a Medical License

☐ I hold a valid Medical License

License/Certificate #*

Issue Date (mm/dd/yyyy)*

Expiration Date (mm/dd/yyyy)*

Does this license/certification level require supervision?* ☐ Yes ☐ No

Board Description*

(Additional) State Medical License

In the State of *

☐ I am in the process of applying for a Medical License

☐ I hold a valid Medical License

License/Certificate #*

Issue Date (mm/dd/yyyy)*

Expiration Date (mm/dd/yyyy)*

Does this license/certification level require supervision?* ☐ Yes ☐ No

Board Description*

(Additional) State Medical License

In the State of *

☐ I am in the process of applying for a Medical License

☐ I hold a valid Medical License

License/Certificate #*

Issue Date (mm/dd/yyyy)*

Expiration Date (mm/dd/yyyy)*

Does this license/certification level require supervision?* ☐ Yes ☐ No

Board Description*

• Indicates Required Field

Alabama Uniform Provider Application

State Drug License

State Drug License

In the State of *

☐ I am in the process of applying for a State Drug Certificate

☐ I hold a State Drug Certificate

Certification #*

Expiration Date (mm/dd/yyyy)*

Please indicate all schedules currently held* ☐ 2 ☐ 2N ☐ 3 ☐ 3N ☐ 4 ☐ 5

Is this certification Limited or restricted?* ☐ No ☐ Yes If yes, please explain:

(Additional) State Drug License

In the State of *

☐ I am in the process of applying for a State Drug Certificate

☐ I hold a State Drug Certificate

Certification #*

Expiration Date (mm/dd/yyyy)*

Please indicate all schedules currently held* ☐ 2 ☐ 2N ☐ 3 ☐ 3N ☐ 4 ☐ 5

Is this certification Limited or restricted?* ☐ No ☐ Yes If yes, please explain:

(Additional) State Drug License

In the State of *

☐ I am in the process of applying for a State Drug Certificate

☐ I hold a State Drug Certificate

Certification #*

Expiration Date (mm/dd/yyyy)*

Please indicate all schedules currently held* ☐ 2 ☐ 2N ☐ 3 ☐ 3N ☐ 4 ☐ 5

Is this certification Limited or restricted?* ☐ No ☐ Yes If yes, please explain:

- Indicates Required Field

Alabama Uniform Provider Application

Federal DEA License

Federal DEA License

☐ I am in the process of applying for a Federal DEA Certificate

☐ My specialty does not require a Federal DEA Certificate

☐ I hold a Federal DEA Certificate OR ☐ I use my hospital's Federal DEA Certificate

Certification #*

Original Issue Date (mm/dd/yyyy)

Expiration Date (mm/dd/yyyy)*

Please indicate all schedules currently held* ☐ 2 ☐ 2N ☐ 3 ☐ 3N ☐ 4 ☐ 5

Is this certification Limited or Restricted?* ☐ No ☐ Yes If yes, please explain:

* Indicates Required Field

Federal DEA License

☐ I am in the process of applying for a Federal DEA Certificate

☐ My specialty does not require a Federal DEA Certificate

☐ I hold a Federal DEA Certificate OR ☐ I use my hospital's Federal DEA Certificate

Certification #*

Original Issue Date (mm/dd/yyyy)

Expiration Date (mm/dd/yyyy)*

Please indicate all schedules currently held* ☐ 2 ☐ 2N ☐ 3 ☐ 3N ☐ 4 ☐ 5

Is this certification Limited or Restricted?* ☐ No ☐ Yes If yes, please explain:

* Indicates Required Field

Alabama Uniform Provider Application

Professional Liability

Please list your Insurance Carrier (Domestic Insurer Only), beginning with the most current. If you have less than 10 years with your current Insurance Carrier, please list your previous Insurance Carriers.

Indicate if this carrier is your* ☐ Current Carrier ☐ Previous Carrier ☐ State Insurance Fund

Name of Carrier*

Street Address

Suite/Building

City

State

ZIP

Telephone Number*

( )

Policy Number

Effective Date (mm/dd/yyyy)

Expiration Date (mm/dd/yyyy) Time with Carrier

Years

Months

Amount of Coverage*

$ /Occurrence ☐ Unlimited Coverage

Amount of Coverage*

$ Aggregate ☐ Unlimited Coverage

Indicate if this carrier is your* ☐ Current Carrier ☐ Previous Carrier ☐ State Insurance Fund

Name of Carrier*

Street Address

Suite/Building

City

State

ZIP

Telephone Number*

( )

Policy Number

Effective Date (mm/dd/yyyy)

Expiration Date (mm/dd/yyyy) Time With Carrier

Years

Months

Amount of Coverage*

$ /Occurrence ☐ Unlimited Coverage

Amount of Coverage*

$ Aggregate ☐ Unlimited Coverage

Make additional copies of this page as necessary

* Indicates Required Field

Alabama Uniform Provider Application

Education

Please enter your undergraduate, graduate and medical school education information. Any additional post-graduate training may also be entered. Please use the official school name.

School Name*

Program* ☐ Graduate School ☐ Medical School ☐ Undergraduate School

Effective Date* Month Year

Ending Date* or ☐ Check if currently in process Month Year

Completed?* ☐ Yes ☐ No

Degree Received*

Is the address within the USA?*

☐ Yes – Enter Address Directly Below

Street Address Suite/Building

City* State* ZIP

☐ No – Enter Address Directly Below

Street Address

City* Country*

School Name*

Program* ☐ Graduate School ☐ Medical School ☐ Undergraduate School

Effective Date* Month Year

Ending Date* or ☐ Check if currently in progress Month Year

Completed?* ☐ Yes ☐ No

Degree Received*

Is the address within the USA?*

☐ Yes – Enter Address Directly Below

Street Address Suite/Building

City* State* ZIP

☐ No – Enter Address Directly Below

Street Address

City* Country*

School Name*

Program* ☐ Graduate School ☐ Medical School ☐ Undergraduate School

Effective Date* Month Year

Ending Date* or ☐ Check if currently in progress Month Year

Completed?* ☐ Yes ☐ No

Degree Received*

Is the address within the USA?*

☐ Yes – Enter Address Directly Below

Street Address Suite/Building

City* State* ZIP

☐ No – Enter Address Directly Below

Street Address

City* Country*

Alabama Uniform Provider Application

Training

Please enter information about your Internship, Residency and Fellowship.

Facility Name*

Training Type* ☐ Internship ☐ Residency ☐ Fellowship ☐ Other Post-Graduate training

Effective Date* Month Year

Ending Date* or ☐ Check if currently in progress Month Year

Completed?* ☐ Yes ☐ No

Program Description*

Is the address within the USA?*

☐ Yes – Enter Address Directly Below

Street Address Suite/Building

City* State* ZIP

☐ No – Enter Address Directly Below

Street Address

City* Country*

Program Director

Title First Name Last Name Suffix

Facility Name*

Training Type* ☐ Internship ☐ Residency ☐ Fellowship ☐ Other Post-Graduate training

Effective Date* Month Year

Ending Date* or ☐ Check if currently in progress Month Year

Completed?* ☐ Yes ☐ No

Program Description*

Is the address within the USA?*

☐ Yes – Enter Address Directly Below

Street Address Suite/Building

City* State* ZIP

☐ No – Enter Address Directly Below

Street Address

City* Country*

Program Director

Title First Name Last Name Suffix

* Indicates Required Field

Alabama Uniform Provider Application

Training

Facility Name*

Training Type* ☐ Internship ☐ Residency ☐ Fellowship ☐ Other Post-Graduate training

Effective Date*
Month Year

Ending Date* or ☐ Check if currently in progress
Month Year

Completed?* ☐ Yes ☐ No

Program Description*

Is the address within the USA?*
☐ Yes – Enter Address Directly Below

Street Address Suite/Building

City* State* ZIP

☐ No – Enter Address Directly Below

Street Address

City* Country*

Program Director
Title First Name Last Name Suffix

Facility Name*

Training Type* ☐ Internship ☐ Residency ☐ Fellowship ☐ Other Post-Graduate training

Effective Date*
Month Year

Ending Date* or ☐ Check if currently in progress
Month Year

Completed?* ☐ Yes ☐ No

Program Description*

Is the address within the USA?*
☐ Yes – Enter Address Directly Below

Street Address Suite/Building

City* State* ZIP

☐ No – Enter Address Directly Below

Street Address

City* Country*

Program Director
Title First Name Last Name Suffix

* Indicates Required Field

Alabama Uniform Provider Application

Board Certification

Please add an entry for each Specialty Board and Certificate

Specialty Board*

Certificate*

Please select one:

☐ I am Board Certified

Certificate Number*

Original Certification Date* (mm/dd/yyyy)

Last Certification Date (mm/dd/yyyy)

Current Expiration Date (if any) (mm/dd/yyyy)

☐ I am in process of taking specialty boards and my exam date is: (mm/dd/yyyy)

Have you ever taken the Board Certifications and failed? ☐ Yes ☐ No

☐ I am not planning to take specialty boards. Please provide a brief explanation

Have you ever taken the Board Certifications and failed? ☐ Yes ☐ No

☐ I am not eligible to take specialty boards. Please provide a brief explanation

Have you ever taken the Board Certifications and failed? ☐ Yes ☐ No

Please make copies of this page if you have additional specialties

* Indicates required field

Alabama Uniform Provider Application

Professional Practice History

Please account for your professional practice history (other than hospital affiliations), from graduate school to present, including any military experience, if applicable.

Office Practice/Institution Name* From (mm/dd/yyyy)* To (mm/dd/yyyy)*

☐ Check if this is a current affiliation

Telephone Number* Position/Rank

( )

Is the address within the USA?*

☐ Yes – Enter Address Directly Below ☐ No – Enter Address Directly Below

Street Address Suite/Building Street Address

City* State* ZIP City* Country*

Office Practice/Institution Name* From (mm/dd/yyyy)* To (mm/dd/yyyy)*

☐ Check if this is a current affiliation

Telephone Number* Position/Rank

( )

Is the address within the USA?*

☐ Yes – Enter Address Directly Below ☐ No – Enter Address Directly Below

Street Address Suite/Building Street Address

City* State* ZIP City* Country*

Office Practice/Institution Name* From (mm/dd/yyyy)* To (mm/dd/yyyy)*

☐ Check if this is a current affiliation

Telephone Number* Position/Rank

( )

Is the address within the USA?*

☐ Yes – Enter Address Directly Below ☐ No – Enter Address Directly Below

Street Address Suite/Building Street Address

City* State* ZIP City* Country*

Make additional copies of this page as necessary

* Indicates Required Field

Alabama Uniform Provider Application

Current Hospital Admitting Privileges

Hospital Admitting Privileges - Please list your current hospital admitting privileges

Hospital Name*

NPI

Street Address

Suite/Building

City

State

ZIP

Telephone Number*

( )

Fax Number

( )

Medical Staff Department*

What is your Staff Category?*

☐ Active ☐ Affiliate ☐ Applied/Pending ☐ Associate ☐ Consulting

☐ Courtesy ☐ None ☐ Provisional ☐ Temporary

If Staff Category is *Applied/Pending*, list Application Date (mm/dd/yyyy)

Effective Date*

Month Year

Re-appointment Date*

Month Year

Admitting Privileges*

☐ My specialty does not admit patients

If your specialty admits patients, please complete the following information:

Percent of patients you admit to this hospital %

☐ I admit my own patients to the hospital

☐ Another practitioner admits on my behalf

If another practitioner admits on your behalf, please provide the following information:

First Name Middle Last Name Suffix

Telephone Number

( )

Specialty

Please explain why another practitioner admits on your behalf:

Make additional copies of this page as necessary

* Indicates Required Field

Alabama Uniform Provider Application

Past Hospital Admitting Privileges

Hospital Admitting Privileges - Please list your past hospital admitting privileges

Hospital Name*

Street Address

Suite/Building

City

State

ZIP

Telephone Number*

( )

Fax Number

( )

Medical Staff Department*

Effective Date*

Month

Year

Ending Date*

Month

Year

What was your Staff Category?*

☐ Active ☐ Affiliate ☐ Applied/Pending ☐ Associate ☐ Consulting

☐ Courtesy ☐ None ☐ Provisional ☐ Temporary

☐ Other_____

What was your standing at this hospital when you left? *

☐ Good Standing ☐ Probation ☐ Restricted ☐ Suspended ☐ Terminated

☐ Other_____

Hospital Name*

Street Address

Suite/Building

City

State

ZIP

Telephone Number*

( )

Fax Number

( )

Medical Staff Department*

Effective Date*

Month

Year

Ending Date*

Month

Year

What was your Staff Category?*

☐ Active ☐ Affiliate ☐ Applied/Pending ☐ Associate ☐ Consulting

☐ Courtesy ☐ None ☐ Provisional ☐ Temporary

☐ Other_____

What was your standing at this hospital when you left?*

☐ Good Standing ☐ Probation ☐ Restricted ☐ Suspended ☐ Terminated

☐ Other_____

Make additional copies of this page as necessary

* Indicates Required Field

Alabama Uniform Provider Application

Comments

Please enter any additional comments that you would like us to know about your application.

Make additional copies of this page as necessary

Alabama Uniform Provider Application

Questionnaire

IMPORTANT: If any of the following questions are answered "Yes," please provide an explanation for each answer. If any questions do not apply to you, please answer "No". Failure to check an answer or provide explanations for "Yes" responses may result in delay of application processing. All questions must be answered.

Education and Training

1. During your education, internship, residency, fellowship, preceptorship or additional training, as applicable were you ever disciplined, suspended, placed on probation, formally reprimanded, or asked to resign? ☐ Yes ☐ No

License Information

2. Have you ever been disciplined, reprimanded, or fined by any state board of medical examiners, professional conduct board, or state of federal agency that disciplines physicians or allied health professionals? ☐ Yes ☐ No

3. Has your license to practice, in your profession, ever been denied, limited, suspended, revoked, or subject to probation or any conditions or limitations in any state? ☐ Yes ☐ No

4. Have you ever been disciplined, suspended, sanctioned, or otherwise restricted from participating in any private, federal or state health plan program (for example, Medicare, Medicaid, CLIA, professional society or managed care organization) or is any such action pending? ☐ Yes ☐ No

5. Have you ever been the subject of any investigation by any private, federal, or state health program – or is any such action pending? ☐ Yes ☐ No

6. Have your Federal DEA and/or State Controlled Dangerous Substance (CDS) Certificate(s) ever been voluntarily or involuntarily limited, suspended, revoked, relinquished, or not renewed – or are proceedings currently pending? ☐ Yes ☐ No

Insurance Information

7. Has your professional liability insurance coverage ever been terminated or modified by action of any insurance company? ☐ Yes ☐ No

8. Have you ever been denied professional liability insurance coverage or rated in a higher-than-average risk class for your specialty? ☐ Yes ☐ No

9. Have any professional liability suits, actions, or claims alleging malpractice ever been filed against you? ☐ Yes ☐ No

10. Are any professional liability suits, actions or claims currently pending against you? ☐ Yes ☐ No

11. Have any judgments ever been made against you in professional liability cases or claims, or have you ever entered into any settlements? ☐ Yes ☐ No

12. To your knowledge, has information pertaining to you ever been reported to the National Practitioner Data Bank? ☐ Yes ☐ No

13. Are you currently uninsured for professional liability staff (malpractice insurance) coverage? ☐ Yes ☐ No

Hospitals and Other Affiliations

14. Has your medical membership or clinical privileges at any hospital or healthcare institution or organization ever been limited, suspended, revoked, not renewed, or subject to probationary or other disciplinary conditions, or have proceedings toward any of these ends been instituted or recommended by any hospital or healthcare institution, medical staff or committee, or governing board? ☐ Yes ☐ No

15. Has your request for any specific clinical privileges been denied or granted with stated limitations (aside from ordinary or initial requirements of proctorship), or has such a denial or limitation been recommended by a medical staff or peer review committee to a governing board? ☐ Yes ☐ No

16. Have you ever had any previous or pending challenges to, or voluntarily or involuntarily relinquished any medical staff membership or clinical privilege(s), as the result of any investigation or disciplinary action? ☐ Yes ☐ No

17. Have you ever been court-martialed, sanctioned, reprimanded, or cautioned by a hospital or any other healthcare facility or military agency; been involuntarily terminated or forced to resign; or have you resigned voluntarily while under investigation or threat of sanction from a hospital or healthcare facility or any military agency? ☐ Yes ☐ No

Board Certification

18. Has your Specialty Board certification or eligibility ever been denied, revoked, relinquished, not renewed, suspended, or reduced – or have any proceedings toward those ends been instituted? ☐ Yes ☐ No

Practice History

19. Are there any gaps in your professional practice history? ☐ Yes ☐ No

Alabama Uniform Provider Application

Questionnaire

Page 2

IMPORTANT: If any of the following questions are answered "Yes," please provide an explanation for each answer. If any questions do not apply to you, please answer "No". Failure to check an answer or provide explanations for "Yes" responses may result in delay of application processing. All questions must be answered.

Health Status

20. Do you have you had a chemical dependency and/or substance abuse problem, treated or untreated?	☐ Yes	☐ No
21. During the last three years have you ever been under the influence of alcohol during working hours, or have you had a chemical dependency and/or substance abuse problem, treated or untreated?	☐ Yes	☐ No
22. Are you unable, with or without reasonable accommodation, to practice to the fullest extent of your license, qualification, and privileges without in any way posing a risk of harm to your patients?	☐ Yes	☐ No

Criminal History

23. Have you ever been arrested for, or charged with, a crime involving children? If "Yes," include the disposition of the arrest or charge on a separate sheet. This statement is being answered under penalty of perjury, subject to applicable Federal punishment of perjury.	☐ Yes	☐ No
24. Have you ever been convicted of a felony or are you presently under investigation or have you ever been indicted for a felony?	☐ Yes	☐ No

Alabama Uniform Provider Application

Provider Authorization

I hereby give permission to the selected entities and/or its designee to request information regarding my professional credentials and qualifications from educational facilities, the chief(s) of the clinical department(s) of the hospital(s) in which I currently have or formerly have had medical staff membership and/or clinical privileges, professional certification boards, state regulatory and licensing departments, professional liability insurance carriers, other professional monitoring entities, and present and past employers.

The information requested may include otherwise privileged or confidential material relative to my professional qualifications, credentials, claims history, clinical and/or professional competence, character, ethics, or any other matter having bearing on the credentialing procedure. I release and agree to hold harmless the selected entities and its affiliates to whom this information is given and their representatives, employees and agents from any and all liability for any damages, costs, and expenses which may result from the gathering or use of such information, as long as such release or use of information is done in good faith and without malice.

I hereby authorize the educational facilities, the chief(s) of the clinical department(s) of the hospital(s) in which I currently have or formerly have had staff privileges, professional certification boards, state regulatory and licensing departments, professional liability carriers, other professional monitoring entities and present and past employers to submit information requested by the selected entities including otherwise privileged or confidential material relative to my professional qualifications, credentials, past and present malpractice coverage, claims and suit information, clinical and/or professional competence, character, ethics, or any other matter having bearing on the credentialing procedure. I hereby further release and agree to hold harmless all such entities, their representatives, employees and agents from any and all liability for any damages which may result from providing this information, as long as such release or use of this information is done in good faith and without malice. I further agree the burden shall be upon me to prove such release was done in bad faith and with malice by a preponderance of evidence.

I agree that a photocopy or facsimile of this document with my signature may be accepted by any person or entity from which such information is sought with the same authority as the original and I specifically waive written notice from any such entities or individuals who may provide information based upon this authorized request.

I represent that the information provided in or attached to this Application and the most current information provided to the selected entities is accurate and complete. I understand that a condition of this Application is that any misrepresentation, misstatement or omission from this Application, whether intentional or not, is cause for automatic and immediate rejection of this Application by the selected entities and may result in denial of my application or termination of my participation in the selected entities. I further understand that any misrepresentation, misstatement or omission from this Application, if discovered after participation has been awarded to me, may lead to immediate suspension or termination of those privileges. I agree to use my best efforts to inform the selected entities in writing within 30 days if there is any change in the information provided or the answers to questions on the Application as a result to developments subsequent to my signing this Application.

I warrant that I have the authority to sign this Application, on my behalf, and on behalf of any entity or organization for which I am signing in a representative capacity. I agree that submission of this Application does not constitute approval or acceptance of this application or me by the entity as a participating provider. I further agree that this application may only qualify as a "pre-application" under the rules of the entity.

I understand that if my application is rejected for reasons relating to my professional conduct or clinical competence, the selected entities may be required to report the rejection to the appropriate state licensing board and/or National Practitioner Data Bank.

This attestation statement must be signed no more than 180 days prior to the credentialing decision. If the credentialing review and decision takes place more than 180 days after the signature below, provider must re-sign and date this application page attesting that all application page attesting that all application information remains current, complete and correct.

☐ I have reviewed and **AGREE** to this attestation statement

☐ I have reviewed and **DO NOT AGREE** to this attestation statement

I UNDERSTAND THAT THIS APPLICATION DOES NOT ENTITLE ME TO PARTICIPATION IN ANY HOSPITAL, HEALTH CARE ENTITY, OR HEALTH PLAN.

The undersigned, being hereby warned that intentional or unintentional false statements and the like so made may jeopardize the validity of the application, declares that he/she is properly authorized to execute this application; and that all statements made of his/her own knowledge are true; and that all statements made on information and belief are believed to be true.

Signature	**Signatory's Name**	**Date:**