Blue Cross® Blue Shield® of Arizona Advantage
Provider Contracting Request and Information Form

Thank you for your interest in becoming a contracted provider. In order to be considered for a contract with Blue Cross Blue Shield of Arizona Advantage (BCBSAZ Advantage) you must successfully complete the credentialing process.

Please complete the enclosed application.

1) If you utilize CAQH, the Council for Affordable Quality Healthcare, BCBSAZ Advantage will accept that application. Please indicate your CAQH ID# in lieu of completing this entire application. **CAQH ID#:_______________**

Then complete pages 1-3 in full.

2) If you do not have CAQH, Please *complete the entire enclosed application and provide* the supporting documentation and return to BCBSAZ Advantage. **Complete pages ALL pages in full and read and sign the Release and Attestation on page 8.**

Supporting documentation includes:

- A **curriculum vitae** (CV) or work history form, **including month and year**, for the last 5 years
- A copy of your **current malpractice insurance certificate**

You have the right to review information submitted by or from other sources in support of your credentialing application, and to correct erroneous information.

NOTE: Any missing items or incomplete required fields will significantly delay the processing of your application.

FAX TO: BCBSAZ Advantage Provider Relations (480)-684-7871

The completion of this form does not guarantee network participation. If you have questions regarding the contracting process Process please contact Provider Network Relations at (480)-684-7712.

PROVIDER NAME and **DEGREE:**	(Last)	(First)	(MI)	Degree (MD, DO, etc.):
	Gender: **M** ☐ **F** ☐ DOB: ___/___/___	SSN:	Birth Place:	
OTHER NAME(S) USED:	(Last)	(First)	(MI)	
Individual NPI: (Required)	**Individual NPI:** ______________________ Eff. date:_____/_____/_____			
Indian Health Care Provider:	Are you an Indian Health Care Provider? **Y** ☐ **N** ☐			
LICENSE:	License #:_______________ Date you were first licensed to practice in AZ: ____/____/____ (Mo, day, year required)			
OTHER ID NUMBERS:	DEA #:__________________ Exp date: ____/____/_____ Medicare B#:______________ Eff date: ____/_____/_____ UPIN ID: ________________ Eff date: ____/____/______			

SPECIALTY / TAXONOMY: Check applicable box: ☐ **Hospital Based** ☐ **Office Based**

Please note, what you indicate as your practicing specialty(s) will be how you are listed in the BCBSAZ Advantage Provider Directories.

Primary Practicing Specialty:____

Other Practicing Specialty(s), as applicable:____

Individual Taxonomy:____________________________

SPECIALTY BOARD CERTIFIED? Y ☐ **N** ☐ If **YES**, please attach a copy of the Board Certificate(s)

Name of Specialty Board:____Certificate#_________

Certified: ___/___/___ Recertified: ___/___/___ Expires: ___/___/___

Name of Specialty Board:____Certificate#_________

Certified: ___/___/___ Recertified: ___/___/___ Expires: ___/___/___

OTHER LANGUAGES SPOKEN BY PHYSICIAN: (Not staff)	1.___________________ 2. __________________3. _______________

HOSPITAL /FREE STANDING SURGERY FACILITIES PRIVILEGES: (REQUIRED)
(Indicate Hospitals/Free Standing Surgery Facilities on an attached sheet)

____☐ACTIVE ☐COURTESY ☐DELIVERY ☐PROVISIONAL

____☐ACTIVE ☐COURTESY ☐DELIVERY ☐PROVISIONAL

____☐ACTIVE ☐COURTESY ☐DELIVERY ☐PROVISIONAL

____☐ACTIVE ☐COURTESY ☐DELIVERY ☐PROVISIONAL

ASC PRIVILEGES:

OFFICE CONTACT:	Name:____ Office E-Mail Address:____ Phone: ( ) _____________________________ Fax: ( )_______________________________

ARE YOU ACCEPTING NEW PATIENTS? Y ☐ **N** ☐

GROUP NAME: (If applicable, may be used as a "payto" for claims processing)	Group Practice Name or (DBA): ____ Group/Organization NPI :________________________________ Eff. date:_______/_______/______
TAX ID and **START DATE:** (Required)	**Tax ID**:______________________ **Start Date**: ___/___/___ (date when this provider starting billing with tax)
BUSINESS WEBSITE:	**Website:**
BUSINESS EMAIL: (not personal email)	**NOTE: Contracts and Correspondence will be sent to Business Email provided** **Email:**

PRIMARY ADDRESS: (Required) (Physical location where services are performed.)	Street:____Suite:_________ City:______________________State:_________Zip:______________ Phone: ( ) ____________________ Fax: ( )______________________ Authorization/Referral Fax: ( )______________________ Office Hours:____

BILLING ADDRESS: (Contracted provider payments will be sent to this address)	Street:____Suite:_________ City:______________________State:_________Zip:_______________ Phone: ( ) ___________________ Fax: ( )______________________
MAILING ADDRESS: (All correspondence will be sent to this address)	Street:____Suite:__________ City:______________________State:_________Zip:_______________ Phone: ( ) ___________________ Fax: ( )______________________ Email:____
CREDENTIALING CORRESPONDENCE (If different than mailing)	Street:____Suite:__________ City:______________________State:_________Zip:______________ Phone: ( ) _____________________ Fax: ( )_____________________
MEDICAL RECORDS: (If different than primary location)	Street:____Suite:__________ City:______________________State:_________Zip:______________ Phone: ( ) _____________________ Fax: ( )____________________ Email:________________________________

ADDITIONAL OFFICE: (Indicate other additional offices on an attached sheet, if necessary)	Street:____Suite:_________ City:______________________State:_________Zip:______________ Phone: ( ) _________________Fax: ( )___________________ Authorization/Referral Fax: ( )_________________ Office Hours:____

Additional Information / Comments:

Authorized Electronic Signature: I am ________________, and I verify that I am authorized to submit this change form on behalf of the provider or provider's agent. I agree that by entering my name in the electronic signature field below, I am authorizing the changes in this form.

/s/____ ___________
Authorized Electronic Signature Date

SUBMIT FORM by email to: BCBSAZAdvantageproviderrelations@azbluemedicare.com or fax to: BCBSAZ Advantage Provider Relations (480) 684-7871 Questions: (480) 684-7712

INITIAL CREDENTIALING INFORMATION

The following items are required to begin the initial credentialing process. If any of the items are not completed/provided with the application, it may cause a delay in the processing of your file and the receipt of a contract.

________ Completed credentialing application, including all questions answered and a signature on the attestation/release

________ If you answered yes to any of the questions, a **typewritten**, detailed explanation, in your own words (or your attorney's), of the case/issue is required (**failure to provide this information will delay the processing of your file**)

________ Current Arizona practice license (**if you do not have your Arizona practice license, we cannot process your file**)

________ Current DEA certificate, if applicable (**if you are required to have a DEA but have not yet obtained one, we cannot process your file)**

________ Current certificate of malpractice insurance for practice in Arizona, with minimum limits of $1,000,000 per occurrence/$3,000,000 aggregate (**if expired, cannot complete file until we receive a current copy**) or completely fill in the insurance portion of the application

________ Completion of residency (MDs and DOs) is required if graduated from medical school after 1991 (if currently in a residency program, we will accept an application within 60 days of completion of the program; **however, we cannot complete the file until we are able to verify from the residency program that you successfully completed the program**)

________ Fellowships (if currently in a fellowship program, we will accept an application, **however, the BCBSAZ Advantage directory will reflect your specialty based upon your residency, not the fellowship.** After completion of the fellowship, you may request a specialty change.)

________ Complete work history, including month and year, for the last 5 years, **with an explanation of any gaps in work history. (Failure to provide the explanation will delay the processing of your file.)**

The following items will automatically disqualify you from receiving a contract:

- License restriction/probation for anything other than alcohol/substance abuse (may apply when the restriction/probation has been lifted)
- Any complaints regarding sexual misconduct (may apply if the complaint is eventually found to be unsubstantiated)
- Substantiated proof of intentional falsification (including or omitting) of medical records, prescriptions or other medical documentation
- Felony plea or conviction of any kind within the previous 6 years (provider may apply and be considered if more than 6 years have elapsed since the date of conviction or plea, and if the provider is not incarcerated or subject to a federal debarment order at the time of reapplication).

This is not a complete listing of BCBSAZ Advantage credentialing requirements. Providing the above information does not guarantee that a provider will meet BCBSAZ Advantage's credentialing requirements.

PLEASE NOTE: A CONTRACT CANNOT BE EXTENDED TO YOU UNTIL YOU HAVE SUCCESSFULLY COMPLETED THE CREDENTIALING PROCESS.
Please fill out this application completely, attach additional sheets if the space to answer is not sufficient, and include all requested supporting documents. Failure to do so will significantly delay the application and credentialing process.

I. PROVIDER QUESTIONAIRE

Please circle "Y" for "Yes" or "N" for "No"

1. Y N Do you have any physical, mental, or substance abuse problems that could, without reasonable accommodation, impede your ability to provide care according to accepted standards of professional performance or pose a threat to the health or safety of patients? **If yes, please explain, and indicate whether you have disclosed this to the regulatory board for your profession, and attach written documentation verifying the report.**
2. Y N Have you ever been convicted of a criminal offense involving the possession, use, purchase, distribution, or sale of drugs? **If yes, please explain.**
3. Y N Has your license to practice medicine in any jurisdiction (including other states) ever been denied, restricted, limited, suspended or revoked? **If yes, please explain.**
4. Y N Have you ever been reprimanded by a licensing agency, including a Stipulation and Order (voluntary or involuntary), Letter of Reprimand, Censure, or any other such activity/action? **If yes, please explain.**
5. Y N Have your privileges or membership at any hospital, institution or managed care organization ever been denied, suspended, reduced or not renewed, or have disciplinary proceedings ever been instituted against you? **If yes, please explain.**
6. Y N Have you ever withdrawn your application for appointment, reappointment of privileges or resigned from the staff of a health care facility or managed care organization before a decision was made by the health care organization's governing board? **If yes, please explain.**
7. Y N Have you been subject to sanctions by a professional standards review organization (PSRO) or by a utilization and quality control peer review organization (PRO)? **If yes, please explain.**
8. Y N Has your narcotic license ever been suspended, revoked, restricted in any manner, voluntarily/involuntarily relinquished, or is it currently being challenged? **If yes, please explain.**
9. Y N To the best of your knowledge, have you ever been or are you under investigation by a regulatory agency (e.g., **state licensing board**, State Department of Health, Medicare, Medicaid or IRS)? **If yes, please explain.**
10. Y N Have you ever been sanctioned, expelled or suspended from receiving payment or voluntarily resigned under threat of same by Medicare, Medicaid, or other Federal programs, HMO, PPO, or any other insurance-type programs or any other authority? **If yes, please explain.**
11. Y N Have you ever been denied professional liability insurance or has your professional liability insurance ever been terminated or not renewed? **If yes, please explain.**
12. Y N Have you ever had a malpractice claim made against you, been a defendant in a malpractice suit, had any settlements made on your behalf, or had claims paid as a result of arbitration? **If yes, please explain.**
13. Y N Have you ever been convicted of a felony or misdemeanor charge, including DUIs, or are there any charges pending? Exclude only non-DUI related misdemeanor traffic violations? **If yes, please explain.**
14. Y N Have you been the subject of an administrative, civil or criminal complaint or investigation regarding sexual conduct? **If yes, please explain.**

Provider Applicant Name: ________________________________

II. CURRICULUM VITAE AND/OR WORK HISTORY

Attach your current curriculum vitae and/or work history to this application, including month and year **for the last 5 years**. Please explain any gaps in your work history.

A Work History Form is attached for your convenience.

III. OTHER STATE LICENSES

Other State Practice Licenses:

(List any health care licenses ever held and an explanation of any licenses that are not current)

____

____

IV. EDUCATION AND TRAINING

Schools

____

Medical, Dental, etc. College Degree Date of Graduation

____

Other professional training Degree Date of Graduation

Internships/Residencies (list every internship or residency begun or completed)

____

Institution Address Type of internship/residency Dates (Month/Yr)

____

Institution Address Type of internship/residency Dates (Month/Yr)

Fellowships

____

Institution Address Type of Fellowship Dates (Month/Yr)

____

Institution Address Type of Fellowship Dates (Month/Yr)

Primary Hospital: ____

V. HOSPITAL AFFILIATION-PRIMARY HOSPITAL ONLY

Dates of Staff Membership: _____/_____/_____ to _____/_____/_____

VI. PROFESSIONAL LIABILITY INSURANCE

Please complete this portion in full for your current malpractice insurance that is in effect **for your Arizona practice (not a residency/fellowship)**, YOU MUST also provide a copy of a current malpractice insurance certificate with this application.

Please note, if your certificate of insurance is not provided, it will significantly delay the processing of your application.

Name of Current Carrier: ____
Effective Date: ______/______/______ Expiration Date: ______/______/______

Amount of Coverage: __________/__________ Policy Number: ___________________________

VII. COVERING PROVIDERS/COVERAGE PLAN

The BCBSAZ Advantage Credentialing Guidelines require that you supply the names of covering providers, in lieu of covering providers, a detailed explanation of your coverage plan would be acceptable. This requirement does not apply to the following provider types: Chiropractors, Pathologists, Radiologists, Hospitalists, Optometrists, Dentists, ER Physicians, Registered Dieticians, Audiologists, Lactation Consultants, Physical Therapists, Occupational Therapists, Speech Therapists, and Urgent Care Providers.

PLEASE LIST THE PROVIDERS WHO WILL COVER IN YOUR ABSENCE:

Name: ___________________________________ Office Phone#: ___________________________

Name: ___________________________________ Office Phone#: ___________________________

24 Hour Coverage? ☐**Y** ☐**N**

If yes:

☐Answering Service, ☐Voice Mail with Instructions to call Answering Service, ☐Voice Mail with other instructions

VIII. RELEASE AND ATTESTATION

All submitted information is considered confidential and shall not be disclosed to third parties other than BCBSAZ Advantage and its employees or contracted credentialing organizations (other than to the physician or practitioner involved) except with respect to the professional peer review activity or as required by federal or state law.

I, ___________________________________, attest that all the information submitted in this application is correct to my best
(Print Full Name)
knowledge and belief. I certify that all questions have been answered fully and completely. I understand any misstatement may constitute cause for denial of my application or termination of my participation agreement. I understand that omission of any information on this application may result in the automatic denial of my application for participation or the termination of my existing contract, whichever is applicable. I understand and agree, that I, as the applicant, have the burden of producing adequate information for proper evaluation of my professional competence, entire malpractice experience, disciplinary action by licensing boards and/or healthcare facilities, character, ethics, and other qualifications and for resolving any questions about such qualifications.

I hereby grant to BCBSAZ Advantage and its authorized agents the right to obtain and confirm documentation and information, including confidential privileged information pertaining to my credentialing application.

For purposes of evaluating my professional competence, character and ethical conduct, I further authorize BCBSAZ Advantage, their professional staffs and legal representatives, to:

1) Contact and consult with any person and/or entity, including but not limited to, administrators and members of the professional staff of any healthcare facility, institution, professional society, or practice with which I have been associated; and
2) Inspect all records and documents, including health records at other treatment facilities, from individuals and organizations that may be material for the evaluation of my professional qualification, including information relating to any disciplinary action, suspension, or curtailment of practice privilege

I hereby release from liability:

1) BCBSAZ Advantage and all of its representatives, peer review committee members, officers, directors, and employees for their acts in good faith and without malice, in connection with evaluating my application and my credentials for qualification; and for disclosing collected information as required for delegated credentialing; and
2) BCBSAZ Advantage peer review committee members, officers, directors, and employees for claims, damages, losses, causes of action, judgments, settlements incurred by them which are caused by or related to intentional misrepresentation or inaccuracy or false statements knowingly made by me; and

3) All individuals, organizations or entities, including but not limited to healthcare facilities in connection with providing and transmitting, if acting in good faith and without malice, related to the subject matter addressed by this application. I consent to the release of such information whether in the form of transcripts, records, tapes, letters, photocopies or duplications of any of the foregoing or verbal statements by hospital or clinic administrators, representatives of clinical departments of hospitals in which I have served on staff, healthcare clinics, state licensing boards or regulatory bodies (by whatever name known in their respective jurisdictions), insurance carriers/agents, governmental agencies including the NPDB-HIPDB, or other individuals or organizations who or which possess information about me. Such information may be released only to BCBSAZ Advantage for the purpose of credentials verification.

I further consent and agree:

1) This authorization is effective for a period of two years or until the next recredentialing date, whichever occurs first.

2) To notify BCBSAZ Advantage immediately of any material changes concerning my professional status; and

3) A facsimile or photocopy of my signature will serve the same as the original.

I understand and accept that BCBSAZ Advantage has the right, at BCBSAZ Advantage's sole discretion, to deny my application to participate in BCBSAZ Advantage, without cause or explanation, or terminate my existing contract in accordance with its terms, whichever is applicable. If I do not have an existing contract with BCBSAZ Advantage, I understand that I *do not have any appeal rights* and will not be eligible to participate as a BCBSAZ Advantage contracted provider unless or until I have received a Letter-of-Welcome as a contracted provider.

This attestation page must be signed by the actual provider who is applying for participation. This signature cannot be a stamp.

____

Signature of Provider Applicant **Date**

IX. WORK/CLINICAL HISTORY/OPTIONAL IF CV SUPPLIED

Please complete the following form showing work/clinical history **for the last 5 years**. You must include month and year, name(s) of school/training facility, practice/group and address of each.

If you send a Curriculum Vitae (cv) it must include month and year for all dates

Date From ***Month***/*Year*	Date To ***Month***/*Year*	Name of School, Practice/Group	Address of School/Facility, Practice/Group

✎NOTE: An explanation must be included for any gaps in your work history. You may use this page or attach a separate page if needed.

FAX TO: BCBSAZ Advantage Provider Relations (480) 684-7871

If you have any questions regarding the contracting process, please contact **Provider Relations at (480) 684-7712.**