Application to Add New Provider Location

Instructions

Please fill out the application and return the items listed below.

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

2) Copy of your State Medical License or Certificate.

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

For your convenience, the following documents may be viewed and/or printed by clicking on this PDF link: http://www.bcbsal.com/provaddloc/pdf/BlueCrossforms.pdf

4) A Tax Payer Identification Number Request - W9 for each tax number.

5) A Hospital Information Release for each hospital that you are currently affiliated with.

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.

Additional questions about your Blue Cross application can be directed to (205) 220-6765.

Thank You

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Practitioner Information

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

Preferred Name | Gender | Social Security Number*

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	☐ CCC SLP	☐ CNM	☐ CNS
☐ CRNA	☐ CSA	☐ CST	☐ CSW	☐ DC
☐ DDS	☐ DDS MD	☐ DMD	☐ DMD MD	☐ DMIN
☐ DO	☐ DPM	☐ EDD	☐ ED S	☐ LCSW
☐ LD	☐ LMFT	☐ LP	☐ LPC	☐ LPN
☐ MA	☐ MD	☐ MD DDS	☐ MD DMD	☐ MD PHD
☐ MED	☐ 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

NPI | NPI Effective Date

* Indicates Required Field

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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

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Practice Information

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

Is your location a residence?* ☐ Yes ☐ No

If residence, please provide

Business License Number _____ Zoning Permit Number _____

Office Hours*

Monday From	To	Tuesday From	To	Wednesday From	To

Thursday From	To	Friday From	To	Saturday From	To	Sunday 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 ( )

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

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

Billing NPI _____ Billing NPI Effective Date _____

Street Address _____ Suite/Building _____

City _____ State _____ ZIP* _____

Office Telephone Number* ( ) Office Fax Number ( )

Office E-Mail Address: _____

• Indicates Required Field

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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

Application to Add New Provider Location

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

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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* Re-appointment Date*

Month Year 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

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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:**

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Contact Information

Please verify that the contact information for this application is current. Any questions about this application will be directed to this person. All information is required.

Contact First Name*

Contact Last Name*

Contact Telephone Number*

Contact E-Mail Address*