



**BlueCross BlueShield
of Alabama**

An Independent Licensee of the Blue Cross and Blue Shield Association

**PREFERRED RADIOLOGY PROVIDER
PROGRAM NEW PHYSICIAN NOTIFICATION**

The Preferred Radiology Provider (PRP) Program New Physician Notification form needs to be completed whenever a Preferred Medical Doctor (PMD) provides services at your location and needs to be considered for addition to the Preferred Radiology Network as an accredited MRI, MRA, CT, CTA or PET provider. The completed form will help Blue Cross and Blue Shield of Alabama identify all new physicians coming into this Network and will allow us to assure that each of these physicians receives all of the benefits of this Network.

Section I			
PRP Group Name		Effective Date	
		Month	Date
New Physician Name		Year	
Office Address			
City	State	Zip	County
E-mail	Office Phone	Fax Number	
Mailing Address			
City	State	Zip	County
Accredited Certification (include copy of accreditation certificate): <input type="checkbox"/> MRI/MRA <input type="checkbox"/> CT/CTA <input type="checkbox"/> PET		Tax ID Number	
Individual NPI (National Provider Identifier)		(or is NPI applied for?)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Printed Name of person completing this form		Contact person's Phone	

Please note that a physician must be a PMD with Blue Cross and that the location must be accredited in MRI, MRA, CT, CTA or PET by an organization approved by Blue Cross before they are eligible to become part of the PRP Network. Once this Preferred Radiology Provider Program New Physician Notification form is completed, fax it to 205-220-9545 or e-mail it to **credentialing@bcsal.com**.

I certify this information is complete and correct to the best of my knowledge.	_____	_____	_____
	Signature of person completing this form	Title	Date



NETWORK INTEREST FORM

This form may be used by providers currently enrolled who have an interest in becoming a Network Provider in the program indicated. New providers must also complete an enrollment application found at <http://www.bcbsal.com/providers/forms.cfm>.

As a provider enrolling with Blue Cross and Blue Shield of Alabama, I would like to express my interest in applying for the Provider Network(s) 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 also 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	Internal Use Only (Effective Date)
	Preferred Medical Doctors (PMD)	MDs and DOs (excludes Psychiatry)	Open	
	Preferred Optometry Network	Optometrist	Open	
	Preferred Podiatry Network	Podiatrist	Open	
	Participating Chiropractor Network	Chiropractors	Open	
	Preferred Physical Therapy Network	Physical Therapist	Open	
	Preferred Occupational Therapy Network	Occupational Therapist	Open	
	Preferred Medical Laboratory (PML)	Clinical Labs with CLIA Certification	Open	
	Preferred Physician Laboratory (PPL)	Physician in-house labs with CLIA Certification	Open	
	Preferred Radiology Service Network	Accredited MRI, MRA, CT, CTA or PET Provider	Open	
	Certified Nurse Practitioner	Licensed Nurse Practitioner	Open	
	Certified Nurse Midwife	Licensed Nurse Midwife	Open	
	Certified Registered Nurse Anesthetists (CRNA)	Licensed CRNA (FEP Only)	Open	
	Participating Home Health Agency	Home Health Agency	Open	
	Participating Durable Medical Equipment (DME)	DME Supplier with physical facility within Alabama	Open	
	Preferred Hospice Network	Hospice agency with AL Dept of Health Certificate	Open	
	ALL Kids Participating Vision Care – ALL Kids Only	Ophthalmologist, Optometrist or Opticians	Open	
	ALL Kids Participating Ambulance – ALL Kids Only	Ambulance Providers	Open	
	Preferred Dentist – Statewide Dental Network	Dentists or Oral Surgeons	Open	
	Blue Advantage – Medicare Advantage Program	Medicare Eligible Participating Providers	Open	
	Blue Advantage – Participating Pharmacy Agreement	(Part B Drugs and Limited DME)	Open	
	Other – (Please Indicate)			

Provider Attestation

I have read and hereby agree to all terms and conditions of the network(s) indicated. I support the intent of the Preferred Care Program(s) and will notify Blue Cross 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, restrictions of 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 the program. I understand Blue Cross will notify in writing of the decision involving network participation and that the effective date will be 30 days from the receipt of the completed application and all required documentation.

Provider Name		Internal Use Only	<input type="text"/>	-	<input type="text"/>
Individual NPI (National Provider Identifier)		<input type="text"/>	Organizational NPI	<input type="text"/>	<input type="text"/>
Practice Name		Tax ID Number			
<input type="text"/>		<input type="text"/>	-	<input type="text"/>	<input type="text"/>
E-mail	Office Phone		Fax Number		

Office Address

City	State	Zip	County
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Mailing Address

City	State	Zip	County
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Provider Signature _____	Date _____
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Submission Instructions

E-mail E-mail the signed and completed form to: Credentialing@bcbsal.org	Fax Fax the signed and completed form to: Attn: Credentialing 1-205-220-9545	Mail Blue Cross and Blue Shield of Alabama , Attn: Credentialing Post Office Box 362142, Birmingham, AL 35236-2142
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ELECTRONIC FUNDS TRANSFER (EFT) AUTHORIZATION AGREEMENT

Check one please.

Initial Setup

Change to Existing EFT Account

Add/Drop Provider

Payee Name		Payee Number					
Individual NPI <i>(National Provider Identifier)</i>				Organizational NPI <i>(if applicable)</i>			
Tax ID Number				NAPB Number <i>(if applicable)</i>			
E-mail		Office Phone		Fax Number			
Office Address							
City		State	Zip	County			
Mailing Address							
City		State	Zip	County			

I (we) hereby authorize Blue Cross and Blue Shield of Alabama to initiate credit entries (deposits) to my (our) checking account at the depository named below (hereinafter called Depository), and to credit the same to such account.

Depository/Bank Name

ABA/Routing Number

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Account Number

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This authority is to remain in full force and effect until Blue Cross and Blue Shield of Alabama has received written notification from me of its termination in such time and in such manner as to afford Blue Cross and Blue Shield of Alabama and DEPOSITORY a reasonable opportunity to act on said notice of termination. Blue Cross and Blue Shield of Alabama reserves the right to return or adjust any errors in accordance with applicable National Automated Clearinghouse Association Operating Rules.

Name

(Please Print)

Phone Number

I certify this information is complete and correct to the _____
 best of my knowledge. Signature Title Date

* Initial updates or changes will require a two week set-up period with the bank. You will continue to receive payments during this period.

FOR INTERNAL USE ONLY

Route completed forms to:

Treasury Operations Department
 Attn: EFT Processor
 Fax: 205-220-2795
 Telephone: 205-220-4745