



PARTICIPATING CHIROPRACTIC APPLICATION

Instructions: Please TYPE responses. This information will be used for your directory listing.

In an effort to maintain a quality chiropractic program, it is necessary to ask some specific questions regarding your practice history. Submission of this form does not guarantee participation in this program.

I. Personal Information

1. LAST Name	SUFFIX	FIRST Name	MIDDLE Name	Title/Degree	Social Security Number
Personal E-Mail Address			NPI Number	Date of Birth	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
Professional License Number			License Issue Date	License Expiration Date	Primary Specialty
Name of Chiropractic School			City and State of Chiropractic School		Year of Graduation
How many hours of continuing chiropractic education do you complete annually?				Foreign Languages Spoken Fluently <input type="checkbox"/> Spanish <input type="checkbox"/> Hindi <input type="checkbox"/> French <input type="checkbox"/> Arabic <input type="checkbox"/> Other _____	
Special or Extended Certifications					

II. Malpractice Information

Name of Professional Liability Carrier	Professional Liability Insurance Per Case \$	Professional Liability Insurance Aggregate \$
	Effective Date	Expiration Date

III. Practice Information (Use separate sheets for additional office locations)

Office Location: Street Address Only – No P.O. Box	City	State	County	ZIP+4
Correspondence Address: Street Address	City	State	County	ZIP+4
Office Telephone Number ()	Appointment Telephone Number ()	Office Fax Number ()	Office E-mail Address ()	
Daily Office hours	Sunday <input type="checkbox"/> AM <input type="checkbox"/> PM <input type="checkbox"/> PM <input type="checkbox"/> PM	Monday <input type="checkbox"/> AM <input type="checkbox"/> PM <input type="checkbox"/> PM <input type="checkbox"/> PM	Tuesday <input type="checkbox"/> AM <input type="checkbox"/> PM <input type="checkbox"/> PM <input type="checkbox"/> PM	Holidays Your Office Closes
	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	
	<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 _____			

IV. Payee Information

Name of Payee as Reported to the IRS	Doing Business As	Federal Employer Identification Number	
Payee Address: Street Address	City	State County ZIP+4	
Billing Office Telephone ()	Billing Office Fax Number ()	Billing Contact Person	Contact Person's Phone/Ext. ()
Tax ID	Organizational/Payee NPI	Office start date	

V. Chiropractic Coverage

Do you have arrangements for 24-hour, seven days per week coverage for your patients? YES NO
 If yes, type of coverage: Answering Service Answering Machine Emergency Room Other _____
 List the chiropractors that cover for you (if applicable).

Name of Covering Chiropractor	NPI	Telephone Number (include area code)

VI. Financial Information

Do you or a family member 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 section

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

VII. Q & A

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

1. Have you ever been convicted of a felony, which was not successfully overturned on appeal? YES NO
2. Have you been subject to any disciplinary action from:
 - a. State Licensure Board YES NO
 - b. Local Chiropractic Society YES NO
 - c. Peer Review Organization YES NO
 - d. Hospital Medical Staff (except failure to complete medical records) YES NO
3. Have you had any restrictions placed on your license/practice privileges due to disciplinary action of abuse of drugs/alcohol? YES NO
4. Have you been expelled, suspended, placed on probation, limited or restricted from receiving Medicare, Medicaid, or other third party programs? YES NO
5. Have you been expelled from a provider network, HMO, etc.? YES NO
6. Have you been restricted, suspended from or denied privileges by any hospital? YES NO
7. Have you ever voluntarily relinquished privileges, which were not due to physical relocation? YES NO
8. Do you now have, or have you ever had, a surcharge from your liability carrier (If yes, specify amount of surcharge) YES NO
9. Have you ever had a judgment against you or a settlement in a professional liability case? YES NO
10. Do you currently have litigation pending against your practice? YES NO
11. Do you currently owe Medicare or Blue Cross and Blue Shield an outstanding balance? (If yes, amount: _____) YES 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? YES NO
13. Has there been a gap of six months or more in your work history? YES NO

VIII. Additional Required Information

Your application will not be processed unless you have enclosed the following:

- Your signed and dated application
- A copy of your current Chiropractic License
- A copy of your Professional Liability Certificate of Insurance from insurance company, coverage, and limits of liability
- A completed W-9 FORM for each tax number
- A completed Network Interest Form
- A copy of an IRS letter identifying your tax name and number or a copy of your Federal Deposit Coupon.
- A written explanation for any current, pending, or past restrictions, limitations, settlements, or other legal actions against or including you or your medical practice, or any other question requiring explanation from section VII

Please furnish the following information regarding a person we may contact in the event of any questions or additional information needs.

Last Name	Suffix	First	Middle
Telephone Number ()	Fax Number ()	E-Mail Address	

IX. Chiropractic Certification Section

I have read the contents of this application and the information contained herein and all documents are true, correct, and complete. I have used reasonable care in determining the truthfulness, correctness and completeness of all information in this application before signing below. If I become aware that any information in this application is not true, correct, or complete, I agree to notify Blue Cross and Blue Shield of Alabama to verify the information contained herein. I agree to notify Blue Cross and Blue Shield of Alabama of any changes in this information within 30 days of the effective date of the change. I understand that a change in the incorporation of my organization or my status as an individual or group biller may require a new application. I am familiar with and agree to abide by the Blue Shield programs that apply to my provider type. I agree that any existing or future overpayment to me by Blue Shield may be recouped by Blue Shield through future payments. I understand that my name and specialty may be listed in directories published by Blue Cross and Blue Shield of Alabama at its discretion but without obligation to do so. I understand that any provider number assigned may be cancelled if no claims activity occurs for a 6-month period. I understand that willful falsification or willful omission of this information could be grounds for termination. I understand that this application alone does not entitle or guarantee participation in any Preferred Provider Program offered by Blue Cross and Blue Shield of Alabama. In the event I am selected to participate in any Preferred Provider Program offered by Blue Cross and Blue Shield of Alabama, this survey and all information will be incorporated by reference, and become part of any Preferred Provider Agreement. My signature here authorizes verification of the information I have provided.

Printed Name of Provider

Provider's Handwritten Signature

Date Signed

Submission Instructions

Please keep a copy for your records and return the completed, signed application and other attachments to:

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



**NETWORK INTEREST
APPLICATION FORM**

This form is required for all new applicants and any provider interested in being added to a network. New providers must also complete an enrollment application found at www.bcbsal.com. Providers adding a new location must submit this form to have Par Status added to the new location.

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 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 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	n/a
	Certified Nurse Practitioner	Licensed Nurse Practitioner	Open	
	Certified Nurse Midwife	Licensed Nurse Midwife	Open	
	Preferred Home Health Agency	Home Health Agency	Open	
	Preferred 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	

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 the Preferred Medical Doctor Agreement with Blue Cross and Blue Shield of Alabama of which this application is a part and in which it is incorporated by reference, if PMD indicated above. I have read and hereby agree to all the other applicable network agreements and to all the 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.

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

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 Edit or Change to Current EFT Account Add / Drop Provider Cancel EFT

Payee Name		Payee Number	
Individual NPI (National Provider Identifier) (10 Digits)		Organizational NPI (10 Digits)	
Tax ID Number (9 Digits)			
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 (9 Digits)	Account Number
<i>(Optional - Attach an original or copy of a voided check.)</i>	

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.

Please Print Name	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 checks during this period.

Please return this form to:

<p>Mail Blue Cross and Blue Shield of Alabama Treasury Operations Department Attn: EFT Processor 450 Riverchase Parkway East Birmingham, AL 35244-2858</p>	<p>Fax Blue Cross and Blue Shield of Alabama Treasury Operations Department Attn: EFT Processor 205-220-2795</p>	<p>For additional information, please contact us at: 205-220-4745</p>
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**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	<input type="text"/> - <input type="text"/>	(or) Social Security Number	<input type="text"/> - <input type="text"/> - <input type="text"/>
			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.
<ol style="list-style-type: none"> 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:			
<ol style="list-style-type: none"> 1. The number shown on this form is my correct taxpayer identification number, and 2. I am not subject to backup withholding because: <ol style="list-style-type: none"> 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). 			
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.