



**HOSPITAL DATA FORM**

**This form is for hospital admitting privileges information only.**

Provider Information			
Provider Name		National Provider Identifier (NPI)	<input type="text"/>
Address			
City		State	Zip
Phone	Fax Number	E-mail	

I hereby attest that: <i>(Check one please)</i> ✓			
<input type="checkbox"/> I do not have any <b>admitting</b> privileges because my specialty does not admit patients.	Specialty		
<input type="checkbox"/> I do not have any privileges because I use a hospitalist.	Hospitalist Name	National Provider Identifier (NPI)	<input type="text"/>
<input type="checkbox"/> I have <b>admitting</b> privileges at:	Primary Hospital		
City	State	Zip	
<i>Additional Hospitals to which you have admitting privileges may be listed on page 2.</i>			
Date my privileges were initially granted at this hospital: <i>(mm/dd/yyyy)</i>			
Next reappointment/review date to continue my privileges at this hospital is: <i>(mm/dd/yyyy)</i>			
My level of admitting privileges at this hospital is: <i>(check one)</i> <input type="checkbox"/> Full <input type="checkbox"/> Temporary <input type="checkbox"/> Courtesy <input type="checkbox"/> None			
<input type="checkbox"/> Applied/Pending Date Applied: <i>(mm/dd/yyyy)</i>		Expected date of Decision: <i>(mm/dd/yyyy)</i>	
My current standing at this hospital is: <i>(check one)</i> <input type="checkbox"/> Good standing with no issues <input type="checkbox"/> Restricted <input type="checkbox"/> Probationary			
<i>If you have any adverse actions from this hospital, including investigations or pending action, please attach a detailed explanation of the situation.</i>			

I also hereby grant permission to this hospital to verify and/or release my information including:
1. The effective date my privileges were initially granted at this hospital
2. The upcoming reappointment/review date for continued privileges at this hospital
3. My current standing at this hospital
4. Any adverse actions upon my privileges, including investigations and pending actions, at this hospital.
5. Any other information that may be pertinent to the evaluation process.
I understand this information will be released to the Credentialing Unit for the purpose of properly evaluating me for participation in the Preferred Care Programs.

Requires original signature of the physician.	
I certify this information is complete and correct to the best of my knowledge.	_____
	Physician Signature
	_____
	Date

Submission Instructions	
<b>Fax</b> Fax the signed and completed form to: Attn: Credentialing <b>1-205-220-9545</b>	<b>Mail</b> <b>Blue Cross and Blue Shield of Alabama</b> , Attn: Credentialing Post Office Box 362142, Birmingham, AL 35236-2142

**Additional Hospitals to which you have admitting privileges**

<input type="checkbox"/> I have <b>admitting</b> privileges at:	Hospital		
City	State	Zip	
Date my privileges were initially granted at this hospital: <i>(mm/dd/yyyy)</i>			
Next reappointment/review date to continue my privileges at this hospital is: <i>(mm/dd/yyyy)</i>			
My level of admitting privileges at this hospital is: <i>(check one)</i> <input type="checkbox"/> Full <input type="checkbox"/> Temporary <input type="checkbox"/> Courtesy <input type="checkbox"/> None			
<input type="checkbox"/> Applied/Pending Date Applied: <i>(mm/dd/yyyy)</i>		Expected date of Decision: <i>(mm/dd/yyyy)</i>	
My current standing at this hospital is: <i>(check one)</i> <input type="checkbox"/> Good standing with no issues <input type="checkbox"/> Restricted <input type="checkbox"/> Probationary			
<i>If you have any adverse actions from this hospital, including investigations or pending action, please attach a detailed explanation of the situation.</i>			
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City	State	Zip	
Date my privileges were initially granted at this hospital: <i>(mm/dd/yyyy)</i>			
Next reappointment/review date to continue my privileges at this hospital is: <i>(mm/dd/yyyy)</i>			
My level of admitting privileges at this hospital is: <i>(check one)</i> <input type="checkbox"/> Full <input type="checkbox"/> Temporary <input type="checkbox"/> Courtesy <input type="checkbox"/> None			
<input type="checkbox"/> Applied/Pending Date Applied: <i>(mm/dd/yyyy)</i>		Expected date of Decision: <i>(mm/dd/yyyy)</i>	
My current standing at this hospital is: <i>(check one)</i> <input type="checkbox"/> Good standing with no issues <input type="checkbox"/> Restricted <input type="checkbox"/> Probationary			
<i>If you have any adverse actions from this hospital, including investigations or pending action, please attach a detailed explanation of the situation.</i>			
<input type="checkbox"/> I have <b>admitting</b> privileges at:	Hospital		
City	State	Zip	
Date my privileges were initially granted at this hospital: <i>(mm/dd/yyyy)</i>			
Next reappointment/review date to continue my privileges at this hospital is: <i>(mm/dd/yyyy)</i>			
My level of admitting privileges at this hospital is: <i>(check one)</i> <input type="checkbox"/> Full <input type="checkbox"/> Temporary <input type="checkbox"/> Courtesy <input type="checkbox"/> None			
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<i>If you have any adverse actions from this hospital, including investigations or pending action, please attach a detailed explanation of the situation.</i>			