



**PREFERRED MEDICAL
LABORATORY APPLICATION (PML)**

Important – Please read the following information before completing the application

This application alone does not entitle or guarantee participation in any Preferred Provider program offered by Blue Cross and Blue Shield of Alabama.

Instructions: Please PRINT or TYPE a response for each question. Please attach the copies of the documents and any additional information requested.

Laboratory Name		
Office Address		
City	State	Zip
Correspondence Address (if different)		
City	State	Zip
Payee/Remit Address		
City	State	Zip
Contact Name		
E-mail	Office Phone	Fax Number
Tax Identification Number (EIN) <i>(IRS documentation must be attached)</i>		Alabama Identification Number and CLIA Certification <i>(Copies must be attached)</i>
Type of Business: <i>(check one)</i>		
<input type="checkbox"/> Solo	<input type="checkbox"/> Partnership	<input type="checkbox"/> Corporation

Name of Owner and/or Officer	Title	Address

List other clinical laboratories in which the owners/officers above have an ownership interest.

Owner	Company Name	Address	EIN/SSN

Additional Required Information

Before mailing, you must include the following information:

- A copy of Alabama State Board of Health License
- A completed W-9 form
- A copy of CLIA Lab certification of compliance
- A Network Interest Form
- A copy of an IRS letter identifying your tax name and number OR a copy of a Federal Deposit Coupon, unless tax exempt

Provider Attestation

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 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 application and all information will be incorporated by reference, and become part of any Preferred Provider Program Agreement. My signature here authorizes verification of the information I have provided. I understand that failure to submit a complete application with all required documentation during the credentialing process could result in the termination of my preferred status.

Printed Name of Provider	Provider's Handwritten Signature	Date Signed

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

Blue Cross and Blue Shield Use Only	Provider # _____	Provider # _____	Provider # _____
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**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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**BlueCross BlueShield
of Alabama**

An Independent Licensee of the Blue Cross and Blue Shield Association

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

(Optional - Attach an original or copy of a voided check.)

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"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	(or) Social Security Number	<input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> <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.