



**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
------	-------	-----	--------

Mailing Address

City	State	Zip	County
------	-------	-----	--------

Provider Signature _____	Date _____
--------------------------	------------

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
---	---