



NON PMD PROVIDER APPLICATION

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. Your responses will be used by the Credentialing Committee and will remain confidential. Please understand that these questions are asked of all participants.

I. General Information

PROVIDER'S LAST NAME	SUFFIX	FIRST NAME	MIDDLE NAME	Preferred Name	Professional Title
Social Security Number	Unique Provider Identification No. (UPIN)		National Provider Identifier (NPI)		ECFMG Number
Date of Birth	County of Birth	State of Birth		Country of Birth <input type="checkbox"/> United States <input type="checkbox"/>	Gender: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
Federal DEA Number	Federal DEA Number Expiration Date		Languages you speak fluently: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> French <input type="checkbox"/> German <input type="checkbox"/> Other		
Are you a U.S. citizen? <input type="checkbox"/> YES <input type="checkbox"/> NO		Legal right to work in the U.S.? <input type="checkbox"/> YES <input type="checkbox"/> NO		Email Address	

A. Medical Education (Attach additional sheets if necessary)

School Name	Dates attended; please include month/years Begin Date: (MM/YYYY) Ended: (MM/YYYY)			Degree Awarded
Street Address	City	State	Zip	Country

B. Postgraduate Education Training: Internship (Attach additional sheets if necessary)

Institution Name	Dates attended; please include month/years Begin Date: (MM/YYYY) Ended: (MM/YYYY)			Degree Awarded
Street Address	City	State	Zip	Country

C. Postgraduate Education Training: Residency/Fellowships

Residency Training Facility (Institution name)	Dates attended; please include month/years Begin Date: (MM/YYYY) Ended: (MM/YYYY)			
Street Address	City	State	Zip	Country
Residency Training Completion Date: (if you have not yet completed residency, enter your expected completion date)			Type of Residency/Fellowship	

II. License Information (For the following state licensing information, write the name of the state in the top blank.)

Name of the state licensed	1.	2.	3.	4.
State license number				
Licensing board				
Date originally licensed				
License expiration date				
State Medicare Provider #				
Number of Category 1 Continuing Medical Education (CME) hours completed yearly				

III. Specialty Information

	Primary Specialty	Other Specialty	Other Specialty
Specialty Name			
Board Certification Status	<input type="checkbox"/> Certified <input type="checkbox"/> Eligible <input type="checkbox"/> Not Certified	<input type="checkbox"/> Certified <input type="checkbox"/> Eligible <input type="checkbox"/> Not Certified	<input type="checkbox"/> Certified <input type="checkbox"/> Eligible <input type="checkbox"/> Not Certified
Name of Board			
Certification Number			
Date Planning to Take Exam if Board Eligible			
Expiration Date			
Date of Recertification			

IV. Practice Location Information (If you practice at additional locations, please provide information on a separate sheet. If applying for the PMD network, please refer to the Primary and Practicing Specialty Information sheet for determination of eligible specialties.)

	Primary Practice Location	Secondary Practice Location	Third Practice Location
Provider Information			
Office Telephone (include area code)			
Appointment Telephone (include area code)			
Office Fax Number (include area code)			
E-mail Address			
Are you accepting new patients?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Date of employment at this location			
Practice Name (DBA)			
Contact Person			
Practice Address – Street			
Practice Address – City, State, Zip			
Handicap Accessible			
Foreign Language Spoke by Staff	<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Sign <input type="checkbox"/> French <input type="checkbox"/> German <input type="checkbox"/> Other _____	<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Sign <input type="checkbox"/> French <input type="checkbox"/> German <input type="checkbox"/> Other _____	<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Sign <input type="checkbox"/> French <input type="checkbox"/> German <input type="checkbox"/> Other _____
TDD Available	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Primary Specialty at this Location			
Primary Specialty at this Location (if different from your primary specialty)			
Correspondence Address – Street			
Correspondence Address – City, State, Zip			
Legal Business Name (Payee)			
Payment/Remittance Address – Street			
Pmt/Remit Address – City, State, Zip			
Pmt/Remit Phone (include area code)			
Pmt/Remit Fax (include area code)			
Federal Taxpayer ID Number			
Payee/Remittance NPI			
Which income reporting form do you receive from your employer or the Internal Revenue Service at the end of the calendar year?	<input type="checkbox"/> 1099 <input type="checkbox"/> W-2 <input type="checkbox"/> 1065-K1	<input type="checkbox"/> 1099 <input type="checkbox"/> W-2 <input type="checkbox"/> 1065-K1	<input type="checkbox"/> 1099 <input type="checkbox"/> W-2 <input type="checkbox"/> 1065-K1
Taxpayer Name			
Tax Exempt?	<input type="checkbox"/> YES - Attach copy of Exemption Certificate from IRS <input type="checkbox"/> NO	<input type="checkbox"/> YES - Attach copy of Exemption Certificate from IRS <input type="checkbox"/> NO	<input type="checkbox"/> YES - Attach copy of Exemption Certificate from IRS <input type="checkbox"/> NO
Is this location address the same as your residence?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Is this location an Urgicenter, After Hours or Urgicare Clinic?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Is this location affiliated with or part of a rural health center?	Practice: _____ Date: _____		
Is this location a nursing home?	<input type="checkbox"/> YES: Name _____ <input type="checkbox"/> NO Tax ID# _____	<input type="checkbox"/> YES: Name _____ <input type="checkbox"/> NO Tax ID# _____	<input type="checkbox"/> YES: Name _____ <input type="checkbox"/> NO Tax ID# _____
Is this location a hospital?	<input type="checkbox"/> YES: Name _____ <input type="checkbox"/> NO Tax ID# _____	<input type="checkbox"/> YES: Name _____ <input type="checkbox"/> NO Tax ID# _____	<input type="checkbox"/> YES: Name _____ <input type="checkbox"/> NO Tax ID# _____

How many patients do you see at your **office** on an average day? _____ How many patients do you see at the **hospital** on an average day? _____

Primary Practice Information

Primary Practice Daily Office hours	Sunday	Monday	Tuesday	Holidays Your Office Closes
	<input type="checkbox"/> AM <input type="checkbox"/> PM _____	<input type="checkbox"/> AM <input type="checkbox"/> PM _____	<input type="checkbox"/> AM <input type="checkbox"/> PM _____	
Wednesday <input type="checkbox"/> AM <input type="checkbox"/> PM _____	Thursday <input type="checkbox"/> AM <input type="checkbox"/> PM _____	Friday <input type="checkbox"/> AM <input type="checkbox"/> PM _____	Saturday <input type="checkbox"/> AM <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 _____

V. Covering Physicians

Do you have physician coverage for your patients 24 hours per day, seven days per week? YES NO

If yes, type of coverage: Answering Service Answering Machine Emergency Room Other _____

List the physicians who cover for you. **Please be sure to include the NPI (National Provider Identifier).**

National Provider Identifier (NPI)	Name of Covering Physician	Effective Date (MM/DD/YYYY)

VI. Hospital Admitting Privileges

List hospitals where you currently have admitting privileges. **If you have any adverse actions from any of these hospitals, including investigations or pending actions, please attach a detailed explanation of the situation(s).**

City	State	Hospital Name and Hospital NPI	Conditions of Admitting Privileges	Effective Date of Privileges	Primary	Current Status
		Name: ----- NPI:	<input type="checkbox"/> Full <input type="checkbox"/> Temporary <input type="checkbox"/> Courtesy <input type="checkbox"/> Applied/Pending <input type="checkbox"/> None	MM/DD/YYYY	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> Good Standing <input type="checkbox"/> Restricted <input type="checkbox"/> Probation <input type="checkbox"/> Suspended <input type="checkbox"/> Terminated, effective _____
		Name: ----- NPI:	<input type="checkbox"/> Full <input type="checkbox"/> Temporary <input type="checkbox"/> Courtesy <input type="checkbox"/> Applied/Pending <input type="checkbox"/> None	MM/DD/YYYY	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> Good Standing <input type="checkbox"/> Restricted <input type="checkbox"/> Probation <input type="checkbox"/> Suspended <input type="checkbox"/> Terminated, effective _____

VII. Financial

Do you 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 question.**

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

Will you be using a billing agency? YES - Attach a copy of the signed contractual agreement with your billing agency and complete the remainder of this section.
 NO - Section VIII.

Name of Billing Agency	Employer ID Number	Contact Person
Street Address	City	State
		Zip
		Country
Telephone Number (include area code)	Fax Number (include area code)	Email Address

Is your practice owned by a Managed Care Organization? (i.e., Phycor, MedPartners, etc.) YES NO

If yes, name of organization: _____

VIII. Malpractice Information

Name of professional liability carrier	Length of time with current carrier	Professional liability insurance aggregate	Professional liability per case
		\$	\$

IX. Other Practice Affiliations

Examples include HMOs, IPAs, PPOs, etc.

Institution or Organization	Affiliation	Address	City	State	Zip	Area Code/Phone	Area Code/Fax

X. Professional Memberships

Organization Name	Member Since (MM/DD/YYYY)	Any Offices Held (include dates)

XI. Question & Answer

If the answer to any of the following questions #1 – #14 is “Yes,” please attach a detailed explanation of each situation.

- | | | |
|--|---|--|
| 1. Have you ever been convicted of a felony, which was not overturned on appeal? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 2. Do you have any restrictions of prescribing privileges due to sanctions or disciplinary measures? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 3. Have you been subject to any disciplinary action from: | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| a. State Licensure Board | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| b. Any professional organization | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| c. Medicare or Medicaid | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| d. Hospital Medical staff (except failure to complete medical records) | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 4. Have you ever had any restrictions placed on your license or practice privileges due to disciplinary action for abuse of drugs or alcohol? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 5. Have you ever been expelled or suspended from receiving Medicare or Medicaid payments? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 6. Have you ever been expelled from a physician network, HMO, etc.? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 7. Have you ever been restricted or suspended from or denied privileges by any hospital not listed in Section VI on Page 3 of this application? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 8. Have you ever voluntarily relinquished privileges? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 9. Do you now or have you ever had a surcharge from your liability carrier? <i>(If yes, specify amount of surcharge)</i> | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 10. Have you ever had a judgment against you or a settlement in a professional liability case? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 11. Do you currently have litigation pending against you involving the practice of medicine? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 12. Do you currently owe Medicare or Blue Cross and Blue Shield an outstanding balance? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 13. 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? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 14. Has there ever been a gap of six months or more in your work history? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 15. Do you utilize clinical pathways in your office practice? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 16. Does your practice utilize reference laboratories? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| <i>If yes, please specify:</i> _____ | | |
| 17. Does your practice utilize the services of one of the following? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| <i>If yes, please indicate type:</i> | | |
| <input type="checkbox"/> Nurse Practitioner | <input type="checkbox"/> Physician Assistants | <input type="checkbox"/> Nurse Midwife |
| <input type="checkbox"/> Hospitalist | <input type="checkbox"/> Others? <i>Please specify:</i> _____ | <input type="checkbox"/> Surgery Assistants |
| 18. Is your office medical documentation generally: | <input type="checkbox"/> Handwritten | <input type="checkbox"/> Transcribed |
| 19. Do you currently use an electronic practice management vendor? | <input type="checkbox"/> YES | <input type="checkbox"/> NO <i>If yes, please name the Vendor:</i> _____ |
| 20. Are you interested in being considered as a participant in a Preferred Provider Network? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| <i>Answering “yes” does not automatically enroll you in any Preferred Provider Program offered by Blue Cross and Blue Shield of Alabama</i> | | |
| 21. Are you performing investigational clinical research? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 22. Are you a Medicare Participating Provider? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |

XII. Additional Required Information (Before mailing, you must include the following. Please check off each item as you attach.)

- | | |
|---|--|
| <input type="checkbox"/> A copy of your current medical license
<input type="checkbox"/> A copy of your DEA certificate
<input type="checkbox"/> A copy of your State Controlled Substance Registration Certificate
<input type="checkbox"/> A copy of your professional liability certificate of insurance from insurance company, coverage, and limits of liability
<input type="checkbox"/> A copy of your Board Certification, or if not certified, copies of all certificates for each level of medical education completed
<input type="checkbox"/> A copy of your Education Commission of Foreign Medical Graduate Certificate, or Fifth Pathway Certificate, if applicable | <input type="checkbox"/> A completed W-9 form for each tax number
<input type="checkbox"/> A copy of an IRS letter identifying your tax name and number OR a copy of your Federal Deposit Coupon (unless tax exempt) for each tax number
<input type="checkbox"/> 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 question requiring explanation
<input type="checkbox"/> Curriculum vitae including months and years of education and work history
<input type="checkbox"/> A completed Hospital Data Form (enclosed)
<input type="checkbox"/> A completed Network Interest Form (enclosed) |
|---|--|

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	

XIII. Physician Certification Section (Please keep a copy of this application and all attachments for your records.)

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

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

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 # _____
--	------------------	------------------	------------------



**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
---	---



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>
--	---	--



**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.



HOSPITAL DATA FORM

This form is for hospital admitting privileges information only.

Provider Information form with fields for Provider Name, National Provider Identifier (NPI), Address, City, State, Zip, Phone, Fax Number, and E-mail.

I hereby attest that: (Check one please) ✓. Form with checkboxes for admitting privileges and fields for Specialty, Hospitalist Name, National Provider Identifier (NPI), Primary Hospital, City, State, Zip, and dates for initial grant and reappointment.

I also hereby grant permission to this hospital to verify and/or release my information including: List of 5 items to be verified and a statement of understanding.

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

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.

Additional Hospitals to which you have admitting privileges

<input type="checkbox"/> I have admitting 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>			
<input type="checkbox"/> I have admitting 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>			
<input type="checkbox"/> I have admitting 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>			