Preferred Home Health
Provider Invitation

Company Name: _____

Office Street Address: _____

Office City, State, Zip: _____

Mailing Address: _____

Mailing City, State, Zip: _____

Provider Number: _____

IRS Tax Number: _____

I, the undersigned Home Health Provider, hereby make application to Blue Cross and Blue Shield of Alabama to participate as a Preferred Home Health Provider in its Preferred Home Health Network. I have read and hereby agree to all the terms and conditions of the Preferred Home Health Network Agreement with Blue Cross and Blue Shield of Alabama of which this application is a part and in which it is incorporated by reference.

I support the purpose and intent of the Preferred Home Health Network and will notify Blue Cross and Blue Shield of Alabama if my practice is restricted in any manner. This includes, but is not limited to, restrictions by my medical liability carrier. I understand that failure to support the program or report any practice restrictions will be grounds for immediate removal from the program.

I understand that prior to acceptance into the Program, my credentials will be verified along with the business need for additional providers in the program.

Date: _____ Signed: _____

Provider Printed/Typed Name: _____

The corporation will notify the applicant in writing of the decision involving participation in the program.

Please return this form with your application to:

Provider Credentialing
Post Office Box 362142
Birmingham, AL 35236-9850

BlueCross BlueShield of Alabama

An Independent Licensee of the Blue Cross and Blue Shield Association.