BlueCross BlueShield of Alabama

An Independent Licensee of the Blue Cross and Blue Shield Association

CONFIDENTIAL RECREDENTIALING VERIFICATION FORM

INSTRUCTIONS: Please PRINT or TYPE a response to each question below. Please attach copies of all required documents indicated in Section X. Information submitted will remain confidential.

I. General Information

Provider's Name (first/middle/last)			Preferred Name	
Title	Social Security Number	**Sex:** ☐ Male ☐ Female	Date of Birth	
Unique Provider Identification Number (UPIN)	ECFMG Number (if applicable)		ECFMG Issue Date	
National Provider Identifier (NPI)	Federal DEA Number		Federal DEA Expiration Date	
Address	City	State	Zip	
Practitioner E-mail Address	Office Telephone	Fax Number		

II. License Information

State Name				
State License Number				
State Medicare Provider Number				
Number of Category 1 Continuing Medical Education (CME) hours completed yearly				

III. Practice Specialty

	Primary	**Secondary**
Specialty Name		
Board Certified? (Yes or No)		
Name of Board		
Certification Number		
Expiration Date		

IV. Malpractice Information

Name of professional liability carrier	Office Telephone	Fax Number

V. Medical Education/Work History (Please update you work and education history since last credentialed and include it with the requested documents.)

Date Ranges (MM/YYYY – MM/YYYY)	**Name of Employer/School**	**City & State of Employer/School**	**Activity(ies)**

VI. 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 ____________________

UPIN	**NPI**	**Name of Covering Physician**	**Effective Date Physician began Covering** (MM/DD/YYYY)

VII. 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 (MM/DD/YYYY)	Primary	Current Status
		Name: ___ NPI:	☐ Full ☐ Temporary ☐ Courtesy ☐ Applied/Pending ☐ None		☐ Yes ☐ No	☐ Good Standing ☐ Restricted ☐ Probation ☐ Suspended ☐ Terminated, effective: ___
		Name: ___ NPI:	☐ Full ☐ Temporary ☐ Courtesy ☐ Applied/Pending ☐ None		☐ Yes ☐ No	☐ Good Standing ☐ Restricted ☐ Probation ☐ Suspended ☐ Terminated, effective: ___

VIII. Financial

Do you have a financial interest or service contract with any other healthcare entity, including but not limited to laboratories, diagnostic facilities, hospitals or home health agencies?

☐ Yes – *Please complete the following.* ☐ No – *Go to next section.*

Company Name	Principal	Federal Tax ID Number	Address/City/State/Zip	Phone	Type of Interest
				( )	
				( )	

IX. Q & A (If you answer YES to any of the following questions # 1- #14, please include a detailed explanation of each situation.

Since you were last credentialed:

1. Have you been convicted of a felony which was not overturned on appeal? ☐ Yes ☐ No
2. Have you been subject to any disciplinary action, including conditions, restrictions, letters of concern, etc., from:
   a. Any State Licensure Board ☐ Yes ☐ No c. Any Peer Review Organization ☐ Yes ☐ No
   b. Any Medical Society ☐ Yes ☐ No d. Hospital Medical Staff *(except failure to complete medical records)* ☐ Yes ☐ No
3. Have you had any restrictions or conditions of prescribing privileges (even if voluntary) ☐ Yes ☐ No
4. Have you had any restrictions or conditions on your license/practice privileges due to substance abuse (even if voluntary)? ☐ Yes ☐ No
5. Do you have any physical, mental, or substance abuse problems that impede your ability to perform according to generally accepted standards of professional performance or that pose a threat to the health and safety of your patients? ☐ Yes ☐ No
6. Have you been expelled or suspended from receiving Medicare or Medicaid payments? ☐ Yes ☐ No
7. Have you been expelled from a physician network, HMO, etc.? ☐ Yes ☐ No
8. Have you been restricted, suspended from, or denied privileges by any hospital? ☐ Yes ☐ No
9. Have you voluntarily relinquished hospital privileges for any reason other than physical relocation (more than 50 miles)? ☐ Yes ☐ No
10. Do you now or have you had a surcharge from your liability carrier (If yes, amount: $________________) ☐ Yes ☐ No
11. Have you had a judgment against you or a settlement in a professional liability case (including out-of-pocket payments)? ☐ Yes ☐ No
12. Do you currently have litigation pending against you? ☐ Yes ☐ No
13. Do you currently owe Medicare or Blue Cross and Blue Shield an outstanding balance? (If yes, amount: $______________) ☐ Yes ☐ No
14. Has there been a gap of six months or more in your work history, other than continued education? ☐ Yes ☐ No
15. Do you utilize clinical pathways in your office practice? (decision trees to assist in making clinical decisions of care) ☐ Yes ☐ No
16. Does your practice utilize one of the following reference laboratories? (If yes, please check all that apply) ☐ Yes ☐ No
    ☐ Laboratory Corporation of America ☐ Other: ________________
17. Does your practice utilize the services of one of the following? (If yes, please check all that apply) ☐ Yes ☐ No
    ☐ Nurse Practitioner ☐ Physician Assistant ☐ Nurse Midwife ☐ Surgery Assistant ☐ Hospitalist ☐ Other: ________________
18. Do you currently use an electronic practice management vendor? ☐ Yes ☐ No If yes, please name the vendor: ________________

X. Additional Information Required (Before sending, you must include the following. Please ✓ off each item as you attach.)

☐	A copy of your current professional liability certificate from your insurance company, including your name, expiration date, and coverage limits
☐	A completed hospital data form (enclosed)
☐	A detailed, written explanation for any YES answers on questions 1-14 in Section IX above.
☐	A complete work & education history for the past 3 years (months and years)

Please furnish the following information regarding a person we may contact in the event we need any additional information.

Contact's Name (first/middle/last)		Preferred Name
Office E-mail Address	Office Telephone	Fax Number

XI. Provider Certification Section (Please keep a copy of this survey and all related documentation for your records.)

I understand and agree that I, the provider, am solely responsible for all information submitted with this recredentialing verification ("survey" or "application"). I have read the contents of this survey and the information contained herein and all documents are true, correct, and complete to the best of my knowledge. 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 of any information in this application that is not true, correct, or complete, I agree to immediately notify Blue Cross and Blue Shield of Alabama. I understand that willful falsification or willful omission of any information, as well as not returning this survey and all requested documentation, could result in termination of my preferred status. I understand that this application does not entitle or guarantee participation in any Preferred Provider Program offered by Blue Cross and Blue Shield of Alabama. 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. 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 included documentation will be incorporated by reference and become part of any Preferred Provider Agreement. My signature below authorizes verification of the information which I have provided herein and certifies that this information is true, correct, and complete to the best of my knowledge.

I certify this information is complete and correct to the best of my knowledge.	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

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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:

Mail	**Fax**	
Blue Cross and Blue Shield of Alabama Treasury Operations Department Attn: EFT Processor 450 Riverchase Parkway East Birmingham, AL 35244-2858	**Blue Cross and Blue Shield of Alabama** Treasury Operations Department Attn: EFT Processor **205-220-2795**	For additional information, please contact us at: **205-220-4745**

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HOSPITAL DATA FORM

This form is for hospital admitting privileges information only.

Provider Information

Provider Name		National Provider Identifier (NPI)
Address		
City	State	Zip
Phone	Fax Number	E-mail

I hereby attest that: *(Check one please)* ✓

☐ I do not have any **admitting** privileges because my specialty does not admit patients. | Specialty

☐ I do not have any privileges because I use a hospitalist. | Hospitalist Name | National Provider Identifier (NPI)

☐ I have **admitting** privileges at: | Primary Hospital

City	State	Zip

Additional Hospitals to which you have admitting privileges may be listed on page 2.

Date my privileges were initially granted at this hospital: *(mm/dd/yyyy)*

Next reappointment/review date to continue my privileges at this hospital is: *(mm/dd/yyyy)*

My level of admitting privileges at this hospital is: *(check one)* ☐ Full ☐ Temporary ☐ Courtesy ☐ None

☐ Applied/Pending Date Applied: *(mm/dd/yyyy)* Expected date of Decision: *(mm/dd/yyyy)*

My current standing at this hospital is: *(check one)* ☐ Good standing with no issues ☐ Restricted ☐ Probationary

If you have any adverse actions from this hospital, including investigations or pending action, please attach a detailed explanation of the situation.

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

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

☐ I have **admitting** privileges at: Hospital

City | State | Zip

Date my privileges were initially granted at this hospital: *(mm/dd/yyyy)*

Next reappointment/review date to continue my privileges at this hospital is: *(mm/dd/yyyy)*

My level of admitting privileges at this hospital is: *(check one)* ☐ Full ☐ Temporary ☐ Courtesy ☐ None
☐ Applied/Pending Date Applied: *(mm/dd/yyyy)* Expected date of Decision: *(mm/dd/yyyy)*

My current standing at this hospital is: *(check one)* ☐ Good standing with no issues ☐ Restricted ☐ Probationary
If you have any adverse actions from this hospital, including investigations or pending action, please attach a detailed explanation of the situation.

☐ I have **admitting** privileges at: Hospital

City | State | Zip

Date my privileges were initially granted at this hospital: *(mm/dd/yyyy)*

Next reappointment/review date to continue my privileges at this hospital is: *(mm/dd/yyyy)*

My level of admitting privileges at this hospital is: *(check one)* ☐ Full ☐ Temporary ☐ Courtesy ☐ None
☐ Applied/Pending Date Applied: *(mm/dd/yyyy)* Expected date of Decision: *(mm/dd/yyyy)*

My current standing at this hospital is: *(check one)* ☐ Good standing with no issues ☐ Restricted ☐ Probationary
If you have any adverse actions from this hospital, including investigations or pending action, please attach a detailed explanation of the situation.

☐ I have **admitting** privileges at: Hospital

City | State | Zip

Date my privileges were initially granted at this hospital: *(mm/dd/yyyy)*

Next reappointment/review date to continue my privileges at this hospital is: *(mm/dd/yyyy)*

My level of admitting privileges at this hospital is: *(check one)* ☐ Full ☐ Temporary ☐ Courtesy ☐ None
☐ Applied/Pending Date Applied: *(mm/dd/yyyy)* Expected date of Decision: *(mm/dd/yyyy)*

My current standing at this hospital is: *(check one)* ☐ Good standing with no issues ☐ Restricted ☐ Probationary
If you have any adverse actions from this hospital, including investigations or pending action, please attach a detailed explanation of the situation.