In order for your provider number to be assigned, additional information MUST be submitted by mail or Fax.

1. A Tax Payer Identification Number Request for each Tax Number.
2. A Hospital Information Release for each hospital that you are currently affiliated with.
3. A *Blue Cross and Blue Shield of Alabama Network Interest Form* must be submitted for participation in certain network programs.
4. Copy of your State Medical License or Certificate

All required documentation should be mailed to:

Blue Cross and Blue Shield of Alabama
Attention: Provider Enrollment and Credentialing
PO Box 362142
Birmingham, Alabama 35236-2142

The required information may also be faxed to 205-220-9545

Once the requested information has been received, Blue Cross can complete the processing of your application. Failure to send the required information may delay the processing of your application.

Please include your Application Control Number on all correspondence.

Additional questions may be directed to 205-220-6765

Thank You
This form should be filled out completely. Please print.

### Part 1: Tax Status

**Name** as it appears on Internal Revenue Service (IRS) Records *(Required)*

<table>
<thead>
<tr>
<th>Employer Identification Number</th>
<th>Social Security Number</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If you are a Sole Proprietor or Single-owner LLC

**Personal name of owner of business** *(Required)*

**DBA (doing business as)** if different from above *(Optional)*

### Part 2: Exemption

If exempt from form 1099 reporting, you must include a copy of your IRS exemption letter.

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:

1. The number shown on this form is my correct taxpayer identification number, and
2. I am not subject to backup withholding because:
   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

<table>
<thead>
<tr>
<th>Signature</th>
<th>Date</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Telephone</th>
<th>Fax</th>
<th>E-mail <em>(optional)</em></th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Tax Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>City</td>
</tr>
</tbody>
</table>

**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.
This form is for hospital admitting privileges information only.

Provider Information

Provider Name

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.

☐ I do not have any privileges because I use a hospitalist.

☒ I have admitting privileges at:

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 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

<table>
<thead>
<tr>
<th>City</th>
<th>State</th>
<th>Zip</th>
</tr>
</thead>
</table>

- Date my privileges were initially granted at this hospital: (mm/dd/yyyy)
- Next reappointment/review date to continue my privileges at this hospital: (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.
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.

<table>
<thead>
<tr>
<th>Network</th>
<th>Eligible Provider</th>
<th>Network Status</th>
<th>Internal Use Only (Effective Date)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preferred Medical Doctor (PMD) Program</td>
<td>MDs and DOs (excludes Psychiatry)</td>
<td>Open</td>
<td></td>
</tr>
<tr>
<td>Preferred Optometry Network</td>
<td>Optometrist</td>
<td>Open</td>
<td></td>
</tr>
<tr>
<td>Preferred Podiatry Network</td>
<td>Podiatrist</td>
<td>Open</td>
<td></td>
</tr>
<tr>
<td>Participating Chiropractor Network</td>
<td>Chiropractors</td>
<td>Open</td>
<td></td>
</tr>
<tr>
<td>Preferred Physical Therapy Network</td>
<td>Physical Therapist</td>
<td>Open</td>
<td></td>
</tr>
<tr>
<td>Preferred Occupational Therapy Network</td>
<td>Occupational Therapist</td>
<td>Open</td>
<td></td>
</tr>
<tr>
<td>Preferred Medical Laboratory (PML)</td>
<td>Clinical Labs with CLIA Certification</td>
<td>Open</td>
<td></td>
</tr>
<tr>
<td>Preferred Physician Laboratory (PPL)</td>
<td>Physician in-house labs with CLIA Certification</td>
<td>Open</td>
<td>n/a</td>
</tr>
<tr>
<td>Participating Physician Assistant</td>
<td>Licensed Physician Assistant</td>
<td>Open</td>
<td></td>
</tr>
<tr>
<td>Participating Nurse Practitioner</td>
<td>Licensed Nurse Practitioner</td>
<td>Open</td>
<td></td>
</tr>
<tr>
<td>Participating Nurse Midwife</td>
<td>Licensed Nurse Midwife</td>
<td>Open</td>
<td></td>
</tr>
<tr>
<td>Preferred Home Health Agency</td>
<td>Home Health Agency</td>
<td>Open</td>
<td></td>
</tr>
<tr>
<td>Preferred Durable Medical Equipment (DME)</td>
<td>DME Supplier with physical facility within Alabama</td>
<td>Open</td>
<td></td>
</tr>
<tr>
<td>Preferred Hospice Network</td>
<td>Hospice agency with AL Dept of Health Certificate</td>
<td>Open</td>
<td></td>
</tr>
<tr>
<td>ALL Kids Participating Vision Care – ALL Kids Only</td>
<td>Ophthalmologist, Optometrist or Opticians</td>
<td>Open</td>
<td></td>
</tr>
<tr>
<td>ALL Kids Participating Ambulance – ALL Kids Only</td>
<td>Ambulance Providers</td>
<td>Open</td>
<td></td>
</tr>
<tr>
<td>Preferred Dentist – Statewide Dental Network</td>
<td>Dentists or Oral Surgeons</td>
<td>Open</td>
<td></td>
</tr>
<tr>
<td>Blue Advantage® – Medicare Advantage Program</td>
<td>Medicare Eligible Participating Providers</td>
<td>Open</td>
<td></td>
</tr>
<tr>
<td>Blue Advantage® – Participating Pharmacy Agreement</td>
<td>(Part B Drugs and Limited DME)</td>
<td>Open</td>
<td></td>
</tr>
</tbody>
</table>

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

Individual NPI (National Provider Identifier)

Organizational NPI

Practice Name

E-mail

Office Phone

Fax Number

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

{Rev. 2/2012}
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

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**

Blue Cross and Blue Shield of Alabama
Treasury Operations Department
Attn: EFT Processor
450 Riverchase Parkway East
Birmingham, AL 35244-2858

**Fax**

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