BlueCross BlueShield of Arizona
An Independent Licensee of the Blue Cross and Blue Shield Association

Blue Cross Blue Shield of Arizona (BCBSAZ)
Facility and Ancillary Request for Participation Form

IF YOU ARE A PROFESSIONAL GROUP, PLEASE FILL OUT THE PROFESSIONAL INFORMATION FORM.

BCBSAZ and TRICARE credentialing and contracting standards require that BCBSAZ obtain, among other things, required information, such as facility name, physical address and Tax ID#. Confidential information is maintained in contracting and credentialing systems at BCBSAZ for in-house tracking, reporting purposes, and payment of claims.

You have the right to review information submitted by or from other sources in support of your credentialing application, and to correct erroneous information.

ALL REQUIRED FIELDS MUST BE COMPLETED.
The completion of this form does not guarantee network participation.

I am requesting: ☐ **BCBSAZ Participation** ☐ **TRICARE Participation** (copy of W9 required)

Electronic Provider: (REQUIRED)	Are you an Electronic Provider? Yes _____ No ______ If you answered No, please call 602-864-4844 or 1-800-656-5656 to set this up.
Facility Name:	Facility Name (Doing Business As): ______________________ Legal Name (if different than above): ______________________ Ownership Structure (i.e., PC, PLLC, LLC, etc.) : ______________________ If your organization is a subunit of a larger organization, or if it is owned, operated, managed by, or affiliated with another organization, please indicate the name and address of the organization: ______________________ ______________________
Facility or Entity Contact:	Contact Name & Title: ______________________ Business Office E-Mail: ______________________ **NOTE: Contracts will be sent to Business Email provided.** Phone Number: ______________ Fax Number: ______________
Business Website:	Website:______________________ **(Optional information – if provided, it will be displayed in online provider directory)**
NPI: : (REQUIRED)	Facility NPI: ______________________ Eff. date:_______/_______/______ Organization NPI (if applicable):______________ Eff. date:_______/_______/______ Organization Name:______________________
Tax ID#: (REQUIRED)	Tax ID#: ______________________ (to be submitted on claims) **Date provider started billing with Tax ID #:______________ (REQUIRED)**

License Information:	Facility Open Date: ______________________ AZ License #: ________________ Date First Issued: _______________ Exp Date: _____________ Name as it appears on the License: ____ Medicare Certified? Yes/No_____ Medicare A #: _________________ Effective Date: ______________ Participate with Medicare? Yes _______ No _______
Accreditation Information:	Is your facility currently accredited? Yes ___ No ___ If yes, please indicate by circling the appropriate accrediting organization: (**Please attach evidence of current accreditation**) AAAHC_______ AAAASF_________ ADA________ AADE_______ AOA (HFAP) _______ ACHC________ ACR____ IAC_____ AASM_________ CABC_________ CARF ________ CHAP_________ KePro _______ TJC (JCAHO)_______ Other Accreditation (Please Specify): ____
Primary Address: (Main location where services are provided)	Street: ____ Suite _______________ City: ______________________________ State: _________ Zip Code: __________________ Phone: ________________Ext: _____ Fax: _______________ Days & Hours of Operation: _________________ **<u>EACH ADDITIONAL LOCATION WILL REQUIRE A SEPARATE FORM</u>**
Credentialing Contact Person and Credentialing Mailing Address **(if different from above):**	Contact Name: __________________________________ Title: ______________________________ Street: ____ Suite __________ City: __________________ State: ________________Zip Code: __________________ Phone: ____________________Ext: ______ Fax: _____________________ E-Mail Address: ____
Mailing Address: (If different than primary location. All correspondence will be sent to this address)	Street: ____ Suite _____________ City: __________________________ State: ___________ Zip Code: ___________________ Phone: _________________Ext: ________ Fax: _____________________

<table>
<tr><td>Medical Records:
(If different than primary location)</td><td colspan="4">Street: ____ Suite ____________
City: ________________________ State: __________ Zip Code: __________________
Phone: ________________Ext: _______ Fax: ____________________</td></tr>
<tr><td>Billing Service:
(If different than primary address)</td><td colspan="4">Name: ____
Street: ____ Suite ____________
City: ________________________ State: __________ Zip Code: _________________
Phone: _________________Ext: _______ Fax: __________________________</td></tr>
<tr><td>Insurance Information:</td><td colspan="4">Please attach a current copy of the facility's Professional Liability [Malpractice] Insurance Certificate with minimum limits of $1M per occurrence, $3M aggregate (the certificate <u>must</u> have the name and physical address of the facility and/or location being credentialed, or a statement from the carrier that all entities/locations owned by your company are covered by the policy, or an addendum from the carrier listing all locations covered by the policy).

Name of Current Carrier: ____

Policy Number: ____________________________ Expiration Date: _______________________</td></tr>
<tr><td rowspan="15">Primary Specialty:

(Check the one most applicable for the facility/entity)</td><td></td><td>Ambulance Company - Air</td><td></td><td>Hospital, Acute Care</td></tr>
<tr><td></td><td>Ambulance Company - Ground</td><td></td><td>Hospital, Long Term Acute Care</td></tr>
<tr><td></td><td>Birthing Center</td><td></td><td>Hospital, Psychiatric</td></tr>
<tr><td></td><td>Ambulatory Surgery Center (ASC)
(includes -Cardiac Cath Lab, >24 Hrs Recovery Care)</td><td></td><td>Behavioral Health, SubAcute
(example: Residential Treatment Center, Rehab Treatment Center)</td></tr>
<tr><td></td><td>Radiology Center – circle all that apply
CT, X-Ray, MRI, PET, Mammography, Ultrasound
ACR Required for CT, MRI, PET</td><td></td><td>Behavioral Health – OP Programs
(example: Partial Hospitalization Program)</td></tr>
<tr><td></td><td>Dialysis Center</td><td></td><td>Skilled Nursing Facility</td></tr>
<tr><td></td><td>Laboratory</td><td></td><td>Extended Active Rehabilitation (EAR)</td></tr>
<tr><td></td><td>Home Health Agency</td><td></td><td>Urgent Care Center</td></tr>
<tr><td></td><td>Home Infusion Care (Pharmacy License Req)</td><td></td><td>DME/Medical Supply</td></tr>
<tr><td></td><td>Infusion Center (OP)</td><td></td><td>Orthotics</td></tr>
<tr><td></td><td>Hospice</td><td></td><td>Prosthetics</td></tr>
<tr><td></td><td>Sleep Lab</td><td></td><td>Optical Dispenser</td></tr>
<tr><td></td><td>Diabetic Education and Training (ADA Required)</td><td></td><td>Hearing Aid Dispenser</td></tr>
<tr><td></td><td>FQHC (Federally Qualified Health Ctr)
- non-hospital</td><td></td><td></td></tr>
</table>

INSTITUTION/ENTITY
RELEASE AND ATTESTATION

The undersigned is authorized to act on behalf of the institution/entity (Entity), and certifies that all information submitted on this application and all attachments hereto are correct, true, and complete to the best of my knowledge. The Entity fully understands that any misstatements in or omissions from this application may constitute cause for denial of participation in the Blue Cross Blue Shield of Arizona (BCBSAZ) network, or the termination of my existing contract, whichever is applicable.

The Entity consents to complete disclosure of and authorization to make available to BCBSAZ, its affiliates or any of their agents all relevant information pertaining to and deemed necessary and appropriate in the investigation and processing of this application, including but not limited to, information obtained through a third party such as an insurance company, licensing authority, accrediting agency, or governmental agency.

The Entity releases and discharges BCBSAZ, its affiliates, and their representatives, credentials committees, administrators, governing bodies, agents, employees and all other persons or entities supplying information to them from liability or claims of any kind or character in any way arising out of inquiries or disclosures made in good faith in connection with this application. The Entity also waives any right of action or other means of redress it may have against any person or entity supplying this information to BCBSAZ.

The Entity also authorizes the release of this information to other credentialing entities within or which contract with BCBSAZ or any of its affiliates and to accrediting organizations.

The Entity agrees to update this application while it is being processed should there be any change in the information provided regarding the Entity that could affect the application or its outcome. A photocopy of this document shall be considered by the recipient to be a signed original.

_______________________________________ __________________________

Signature Date

_______________________________________ __________________________

Print Name Title

Authorized representative of: ____

Institution/Entity

FAX TO: BCBSAZ Network Management (602) 864-3142 Questions: (602) 864-4231