

Blue Cross Blue Shield of Arizona Provider Contracting Request and Information Form

Thank you for your interest in becoming a contracted provider. In order to be considered for a contract with Blue Cross Blue Shield of Arizona (BCBSAZ) and/or TriWest Healthcare Alliance (TRICARE), you must successfully complete the credentialing process. Please complete the enclosed application and provide the supporting documentation and return to BCBSAZ.

Supporting documentation includes:

- A **curriculum vitae (CV)** or work history form, **including month and year**, for the last 5 years
- A copy of your **current malpractice insurance certificate**

If you utilize CAQH, the Council for Affordable Quality Healthcare, BCBSAZ will accept that application. Please indicate your CAQH ID# on the application in lieu of completing the entire application.

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

I am requesting: **BCBSAZ Participation** **TRICARE Participation (W9 Required)**

ELECTRONIC PROVIDER : (Required)	Are you an Electronic Provider? <input type="checkbox"/> Y <input type="checkbox"/> N If No, please call 602-864-4844 or 1-800-656-5656.			
PROVIDER NAME and DEGREE:	(Last)		(First)	
	(MI)	Degree (MD, DO, etc.):		
OTHER NAME(S) USED:	Gender: M <input type="checkbox"/> F <input type="checkbox"/>	DOB: ___/___/___	SSN: _____	Birth Place: _____
	(Last)		(First)	
GROUP NAME: (If applicable)	Group Practice Name (DBA): _____			
	*A provider who is active duty or a MTF employee is not eligible to participate as a TRICARE provider.			
TRICARE: (Required if requesting participation)	1099 Registered Name: _____			
	Patient Capacity: _____ (Tricare Primary Care Managers Only) Do you want to be a PCM? Y <input type="checkbox"/> N <input type="checkbox"/>			
TAX ID and START DATE: (Required)	Tax ID: _____ Start Date at current practice: ___/___/___			
BUSINESS WEBSITE:	Website: _____			
GYM AFFILIATION: (Required)	Do you provide services at a gym or fitness center? Y <input type="checkbox"/> N <input type="checkbox"/>			

SPECIALTY(IES)
<p>Please note, what you indicate as your practicing specialty (ies) will be how you are listed in the BCBSAZ and/or TRICARE Provider Directories.</p> <p>Primary Practicing Specialty: _____</p> <p>Other Practicing Specialty(ies), as applicable: _____</p>

BOARD CERTIFIED? Y <input type="checkbox"/> N <input type="checkbox"/> If YES , please attach a copy of the Board Certificate(s)	
Name of Specialty Board: _____	Certificate# _____
Certified: ___/___/___	Recertified: ___/___/___
Expires: ___/___/___	
Name of Specialty Board: _____	
Certificate# _____	
Certified: ___/___/___	Recertified: ___/___/___
Expires: ___/___/___	

NPI: : (REQUIRED)	Individual NPI: _____ Eff. date: ___/___/___	
PLEASE PROVIDE A COPY OF YOUR CONFIRMATION FROM NPPES	Organization NPI (if applicable): _____ Eff. date: ___/___/___	
	Organization Name: _____	
TAXONOMY:	Individual Taxonomy: _____ Organization Taxonomy: _____	
LICENSE:	What year did you receive your first license to practice, if other than AZ? _____ State: _____	
	What year were you first licensed to practice in AZ? _____ AZ License#: _____	
OTHER ID NUMBERS:	Medicare #: _____ A <input type="checkbox"/> B <input type="checkbox"/>	DEA #: _____ Exp date: ___/___/___
	Eff date: ___/___/___	UPIN ID: _____ Eff date: ___/___/___
		ECFMG # (if applicable) _____

HOSPITAL /FREE STANDING SURGERY FACILITIES PRIVILEGES: (REQUIRED) (Indicate Hospitals/Free Standing Surgery Facilities on an attached sheet)	
_____	<input type="checkbox"/> ACTIVE <input type="checkbox"/> COURTESY <input type="checkbox"/> DELIVERY <input type="checkbox"/> PROVISIONAL
_____	<input type="checkbox"/> ACTIVE <input type="checkbox"/> COURTESY <input type="checkbox"/> DELIVERY <input type="checkbox"/> PROVISIONAL
_____	<input type="checkbox"/> ACTIVE <input type="checkbox"/> COURTESY <input type="checkbox"/> DELIVERY <input type="checkbox"/> PROVISIONAL
_____	<input type="checkbox"/> ACTIVE <input type="checkbox"/> COURTESY <input type="checkbox"/> DELIVERY <input type="checkbox"/> PROVISIONAL
ASC PRIVILEGES:	

OTHER LANGUAGES SPOKEN BY PHYSICIAN: (Not staff)	1. _____
	2. _____
	3. _____

OFFICE CONTACT:	Name: _____
	Office E-Mail Address: _____
	Phone: () _____ Fax: () _____
	Authorization/Referral Fax: () _____

PRIMARY ADDRESS: (Physical location where services are performed)	Street: _____ Suite: _____
	City: _____ State: _____ Zip: _____
	Phone: () _____ Fax: () _____ Office Hours: _____
	Authorization/Referral Fax: () _____

BILLING ADDRESS: (All payments will be sent to this address)	Street: _____ Suite: _____
	City: _____ State: _____ Zip: _____
	Phone: () _____ Fax: () _____
	Authorization/Referral Fax: () _____

BILLING SERVICE: (If applicable)	Name: _____
	Address: _____ Suite _____
	City: _____ State: _____ Zip: _____
	Phone: () _____ Fax: () _____

MEDICAL RECORDS: If different than primary location)	Street: _____ Suite: _____
	City: _____ State: _____ Zip: _____
	Phone: () _____ Fax: () _____
	Authorization/Referral Fax: () _____

MAILING ADDRESS: (All correspondence will be sent to this address)	Street: _____ Suite: _____
	City: _____ State: _____ Zip: _____
	Phone: () _____ Fax: () _____ Office Hours: _____

CREDENTIALING CORRESPONDENCE (If different than above)	Street: _____ Suite: _____
	City: _____ State: _____ Zip: _____
	Phone: () _____ Fax: () _____
	Email: _____

ADDITIONAL OFFICE: (Indicate other additional offices on an attached sheet)	Street: _____ Suite: _____
	City: _____ State: _____ Zip: _____
	Phone: () _____ Fax: () _____ Office Hours: _____
	Authorization/Referral Fax: () _____

Signature _____

Date _____

I. CAQH UTILIZATION

Do you have a "Completed" CAQH application that is usable in Arizona? CAQH ID# _____

If **No**, do you want a CAQH number issued to this provider? Y N

****If you utilize CAQH, the Council for Affordable Quality Healthcare, BCBSAZ will accept that application. If you indicated a CAQH ID, BYPASS THE REMAINING APPLICATION.**

Before submitting, you must **Read** and **Sign Section IX**, the **RELEASE AND ATTESTATION**, on page 8.

II. PROVIDER QUESTIONNAIRE

If you answer "Yes" to any of the following questions, please provide a TYPEWRITTEN explanation

Please circle "Y" for "Yes" or "N" for "No"

1. Y N Do you have any physical, mental, or substance abuse problems that could, without reasonable accommodation, impede your ability to provide care according to accepted standards of professional performance or pose a threat to the health or safety of patients? **If yes, please explain, and indicate whether you have disclosed this to the regulatory board for your profession, and attach written documentation verifying the report.**
2. Y N Have you ever been convicted of a criminal offense involving the possession, use, purchase, distribution, or sale of drugs? **If yes, please explain.**
3. Y N Has your license to practice medicine in any jurisdiction (including other states) ever been denied, restricted, limited, suspended or revoked? **If yes, please explain.**
4. Y N Have you ever been reprimanded by a licensing agency, including a Stipulation and Order (voluntary or involuntary), Letter of Reprimand, Censure, or any other such activity/action? **If yes, please explain.**
5. Y N Have your privileges or membership at any hospital, institution or managed care organization ever been denied, suspended, reduced or not renewed, or have disciplinary proceedings ever been instituted against you? **If yes, please explain.**
6. Y N Have you ever withdrawn your application for appointment, reappointment of privileges or resigned from the staff of a health care facility or managed care organization before a decision was made by the health care organization's governing board? **If yes, please explain.**
7. Y N Have you been subject to sanctions by a professional standards review organization (PSRO) or by a utilization and quality control peer review organization (PRO)? **If yes, please explain.**
8. Y N Has your narcotic license ever been suspended, revoked, restricted in any manner, voluntarily/involuntarily relinquished, or is it currently being challenged? **If yes, please explain.**
9. Y N To the best of your knowledge, have you ever been or are you under investigation by a regulatory agency (e.g., **state licensing board**, State Department of Health, Medicare, Medicaid or IRS)? **If yes, please explain.**
10. Y N Have you ever been sanctioned, expelled or suspended from receiving payment or voluntarily resigned under threat of same by Medicare, Medicaid, or other Federal programs, HMO, PPO, or any other insurance-type programs or any other authority? **If yes, please explain.**
11. Y N Have you ever been denied professional liability insurance or has your professional liability insurance ever been terminated or not renewed? **If yes, please explain.**
12. Y N Have you ever had a malpractice claim made against you, been a defendant in a malpractice suit, had any settlements made on your behalf, or had claims paid as a result of arbitration? **If yes, please explain.**
13. Y N Have you ever been convicted of a felony or misdemeanor charge, including DUIs, or are there any charges pending? Exclude only non-DUI related misdemeanor traffic violations? **If yes, please explain.**
14. Y N Have you been the subject of an administrative, civil or criminal complaint or investigation regarding sexual conduct? **If yes, please explain.**

Provider Applicant Name: _____

III. INITIAL CREDENTIALING INFORMATION

The following items are required to begin the initial credentialing process. If any of the items are not completed/provided with the application, it may cause a delay in the processing of your file and the receipt of a contract.

- _____ Completed credentialing application, including all questions answered and a signature on the attestation/release
- _____ If you answered yes to any of the questions, a **typewritten**, detailed explanation, in your own words (or your attorney's), of the case/issue is required (**failure to provide this information will delay the processing of your file**)
- _____ Current Arizona practice license (**if you do not have your Arizona practice license, we cannot process your file**)
- _____ Current DEA certificate, if applicable (**if you are required to have a DEA but have not yet obtained one, we cannot process your file**)
- _____ Current certificate of malpractice insurance for practice in Arizona, with minimum limits of \$1,000,000 per occurrence/\$3,000,000 aggregate (**if expired, cannot complete file until we receive a current copy**) or completely fill in the insurance portion of the application
- _____ Completion of residency (MDs and DOs) is required if graduated from medical school after 1991 (if currently in a residency program, we will accept an application within 60 days of completion of the program; **however, we cannot complete the file until we are able to verify from the residency program that you successfully completed the program**)
- _____ Fellowships (if currently in a fellowship program, we will accept an application, **however, the BCBSAZ directory will reflect your specialty based upon your residency, not the fellowship**. After completion of the fellowship, you may request a specialty change.)
- _____ Complete work history, including month and year, for the last 5 years, **with an explanation of any gaps in work history. (Failure to provide the explanation will delay the processing of your file.)**

The following items will automatically disqualify you from receiving a contract:

- License restriction/probation for anything other than alcohol/substance abuse (may apply when the restriction/probation has been lifted)
- Any complaints regarding sexual misconduct (may apply if the complaint is eventually found to be unsubstantiated)
- Substantiated proof of intentional falsification (including or omitting) of medical records, prescriptions or other medical documentation
- Felony plea or conviction of any kind within the previous 6 years (provider may apply and be considered if more than 6 years have elapsed since the date of conviction or plea, and if the provider is not incarcerated or subject to a federal debarment order at the time of reapplication).

This is not a complete listing of BCBSAZ and/or TRICARE credentialing requirements. Providing the above information does not guarantee that a provider will meet BCBSAZ's or TRICARE's credentialing requirements.

PLEASE NOTE: A CONTRACT CANNOT BE EXTENDED TO YOU UNTIL YOU HAVE SUCCESSFULLY COMPLETED THE CREDENTIALING PROCESS.

Please fill out this application completely, attach additional sheets if the space to answer is not sufficient, and include all requested supporting documents. Failure to do so will significantly delay the application and credentialing process.

PLEASE LIST THE PROVIDERS WHO WILL COVER IN YOUR ABSENCE:

Name: _____ Office Phone#: _____

Name: _____ Office Phone#: _____

IV. OTHER STATE PRACTICE LICENSES

(List any health care licenses ever held and an explanation of any licenses that are not current)

State	License Number	Explanation if not current

V. EDUCATION/TRAINING

Schools

Medical, Dental, Chiropractic, etc. College	Degree	Date of Graduation
Other professional training	Degree	Date of Graduation

Internships/Residencies (list every internship or residency begun or completed)

Institution	Address	Type of internship/residency	Dates (Month/Yr)
Institution	Address	Type of internship/residency	Dates (Month/Yr)

Fellowships

Institution	Address	Type of Fellowship	Dates (Month/Yr)
Institution	Address	Type of Fellowship	Dates (Month/Yr)

VI. HOSPITAL AFFILIATION

Primary Hospital: _____
 Department: _____ Category: _____
 Dates of Staff Membership: ____/____/____ to ____/____/____

VII. PROFESSIONAL LIABILITY INSURANCE

Please complete this portion in full for your current malpractice insurance that is in effect **for your Arizona practice (not a residency/fellowship)**, or provide a copy of a current malpractice insurance certificate with this application. Please note, by signing the attached attestation, you are attesting to the accuracy of all the information contained in this application.

Name of Current Carrier: _____
 Effective Date: ____/____/____ Expiration Date: ____/____/____
 Amount of Coverage: _____/_____ Policy Number: _____

VIII. WORK/CLINICAL HISTORY

Please complete the following form showing work/clinical history **for the last 5 years**. You must include month and year, name(s) of school/training facility, practice/group and address of each.

Attach your current curriculum vitae and/or work history to this application, including month and year **for the last 5 years**. Please explain any gaps in your work history.

If you send a Curriculum Vitae (cv) it must include month and year for all dates

Date From <i>Month/Year</i>	Date To <i>Month/Year</i>	Name of School, Practice/Group	Address of School/Facility, Practice/Group

↳NOTE: An explanation must be included for any gaps in your work history. You may use this page or attach a separate page if needed.

IX. RELEASE AND ATTESTATION

All submitted information is considered confidential and shall not be disclosed to third parties other than BCBSAZ and its employees (other than to the physician or practitioner involved) except with respect to the professional peer review activity or as required by federal or state law.

I, _____, attest that all the information submitted in this application is correct to my best
(Print Full Name)

knowledge and belief. I certify that all questions have been answered fully and completely. I understand any misstatement may constitute cause for denial of my application or termination of my participation agreement. I understand that omission of any information on this application may result in the automatic denial of my application for participation or the termination of my existing contract, whichever is applicable. I understand and agree, that I, as the applicant, have the burden of producing adequate information for proper evaluation of my professional competence, entire malpractice experience, disciplinary action by licensing boards and/or healthcare facilities, character, ethics, and other qualifications and for resolving any questions about such qualifications.

I hereby grant to BCBSAZ and its authorized agents the right to obtain and confirm documentation and information, including confidential privileged information pertaining to my credentialing application.

For purposes of evaluating my professional competence, character and ethical conduct, I further authorize BCBSAZ, their professional staffs and legal representatives, to:

- 1) Contact and consult with any person and/or entity, including but not limited to, administrators and members of the professional staff of any healthcare facility, institution, professional society, or practice with which I have been associated; and
- 2) Inspect all records and documents, including health records at other treatment facilities, from individuals and organizations that may be material for the evaluation of my professional qualification, including information relating to any disciplinary action, suspension, or curtailment of practice privilege

I hereby release from liability:

- 1) BCBSAZ and all of its representatives, peer review committee members, officers, directors, and employees for their acts in good faith and without malice, in connection with evaluating my application and my credentials for qualification; and for disclosing collected information as required for delegated credentialing; and
- 2) BCBSAZ peer review committee members, officers, directors, and employees for claims, damages, losses, causes of action, judgments, settlements incurred by them which are caused by or related to intentional misrepresentation or inaccuracy or false statements knowingly made by me; and
- 3) **All individuals, organizations or entities, including but not limited to healthcare facilities in connection with providing and transmitting, if acting in good faith and without malice, related to the subject matter addressed by this application. I consent to the release of such information whether in the form of transcripts, records, tapes, letters, photocopies or duplications of any of the foregoing or verbal statements by hospital or clinic administrators, representatives of clinical departments of hospitals in which I have served on staff, healthcare clinics, state licensing boards or regulatory bodies (by whatever name known in their respective jurisdictions), insurance carriers/agents, governmental agencies including the NPDB-HIPDB, or other individuals or organizations who or which possess information about me. Such information may be released only to BCBSAZ for the purpose of credentials verification.**

I further consent and agree:

- 1) This authorization is effective for a period of two years or until the next recredentialing date, whichever occurs first.
- 2) To notify BCBSAZ immediately of any material changes concerning my professional status; and
- 3) A facsimile or photocopy of my signature will serve the same as the original.

I understand and accept that BCBSAZ has the right, at BCBSAZ's sole discretion, to deny my application to participate in BCBSAZ, without cause or explanation, or terminate my existing contract in accordance with its terms, whichever is applicable. If I do not have an existing contract with BCBSAZ, I understand that I *do not have any appeal rights* and will not be eligible to participate as a BCBSAZ contracted provider unless or until I have received a Letter-of-Welcome as a contracted provider.

Signature of Provider Applicant

Date

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

*If you have questions regarding the contracting process, please contact **Provider Network Relations at (602) 864-4231 or (800)232-2345 ext. 4231.***