



Blue Cross Blue Shield of Arizona Facility/Ancillary Request for Contracting and Information Form

BCBSAZ and TRICARE contracting and credentialing standards require that BCBSAZ obtain, among other things, personal information, such as your name and address. Confidential information is maintained in contracting and credentialing databases at BCBSAZ for in-house tracking, reporting purposes, contracting, credentialing and payment of claims.

IN ORDER TO BE CONTRACTED, YOU MUST HAVE AN NPI AND SUBMIT CLAIMS ELECTRONICALLY. TO CONTINUE PROCESSING, ALL REQUIRED FIELDS MUST BE COMPLETED.

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.
Facility Name:	Facility Name (Doing Business As): _____ Legal Name (if different than above): _____ Ownership Structure (Tricare Only): _____ (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: _____ _____
Administrative Contact:	Contact Name: _____ Office E-Mail Address: _____ Phone Number: _____ Fax Number: _____ Business Website: _____
Credentialing Contact Person and Credentialing Mailing Address: (All Credentialing information will be sent to this contact at this address)	Contact Name: _____ Title: _____ Street: _____ Suite _____ City: _____ State: _____ Zip Code: _____ Phone: _____ Ext: _____ Fax: _____ E-Mail Address: _____
NPI: (REQUIRED) Please provide a copy of your NPI confirmation from NPPES	Organization NPI: _____ Effective Date: _____ Organization Name: _____

Taxonomy:	Organization Taxonomy: _____	
Tax ID: (REQUIRED) Secondary ID's:	Tax ID#: _____	Are you Medicare Certified? Yes ___ No ___
	Date provider started billing w/tax ID: _____ (REQUIRED)	Medicare #: _____ A ___ B ___ Effective Date: _____
	DEA#: _____ Eff Date: _____	Do you participate with Medicare? Yes _____ No _____
License Information:	Facility Open Date: _____ AZ License #: _____ Date First Issued: _____ Exp Date: _____ Name as it appears on the License: _____	
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 _____ AOA _____ ACHC _____ ACR _____ IAC _____ AASM _____ CABC _____ CHAP _____ JCAHO _____ Other Accreditation (Please Specify): _____	
Gym Affiliation: (REQUIRED)	Do you provide services at a gym or fitness center? Yes _____ No _____	
Primary Address: (Main location where services are provided)	Street: _____ Suite _____ City: _____ State: _____ Zip Code: _____ Phone: _____ Ext: _____ Fax: _____ Office Hours: _____	

EACH ADDITIONAL LOCATION WILL REQUIRE A SEPARATE APPLICATION.

Contract will be mailed to this address unless otherwise noted

Mailing Address: (All contracting correspondence will be sent to this address)	Street: _____ Suite _____ City: _____ State: _____ Zip Code: _____ Phone: _____ Ext: _____ Fax: _____
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Billing Address: (All payments will be sent to this address)	Street: _____ Suite _____
	City: _____ State: _____ Zip Code: _____
	Phone: _____ Ext: _____ Fax: _____
Billing Service: (If applicable)	Name: _____
	Street: _____ Suite _____
	City: _____ State: _____ Zip Code: _____
	Phone: _____ Ext: _____ Fax: _____

Insurance Information:	Please attach a copy of the facility's Professional Liability [Malpractice] Insurance Certificate with minimum limits of \$1M per occurrence, \$3M aggregate (the certificate must 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: _____
	Effective Date: _____ Expiration Date: _____
	Amount of Coverage: _____ Policy Number: _____

Specialty Information: Please indicate area(s) of specialty for your facility type. Please indicate Primary specialty and Secondary specialty, where applicable.	Please check all that apply:	
	<input type="checkbox"/> Ambulance Company (Air or Ground)	<input type="checkbox"/> Mammography Center
	<input type="checkbox"/> Ambulatory Surgery Center (ASC)	<input type="checkbox"/> MRI Center (ACR Required)
	<input type="checkbox"/> Audiology	<input type="checkbox"/> Optical Dispenser
	<input type="checkbox"/> Birthing Center	<input type="checkbox"/> Orthotics
	<input type="checkbox"/> Cardiac Cath Lab	<input type="checkbox"/> Pain Management Clinic
	<input type="checkbox"/> Cardiac Rehab Program	<input type="checkbox"/> Partial Hospital Program (Tricare Only)
	<input type="checkbox"/> CT (ACR Required)	<input type="checkbox"/> PET Center (ACR Required)
	<input type="checkbox"/> Diabetic Education (ADA Cert Required)	<input type="checkbox"/> Portable X-Ray
	<input type="checkbox"/> DME/Medical Supply	<input type="checkbox"/> Prosthetics
	<input type="checkbox"/> Dialysis Center	<input type="checkbox"/> Radiation Therapy Clinic
	<input type="checkbox"/> Extended Active Rehab	<input type="checkbox"/> Radiology Center
	<input type="checkbox"/> FQHC (Federally Qualified Health Center)	<input type="checkbox"/> Recovery Center
	<input type="checkbox"/> Hearing Aid Dispenser	<input type="checkbox"/> Rehab Treatment Center (Substance Use)
	<input type="checkbox"/> Home Health Agency	<input type="checkbox"/> Residential Treatment Center
	<input type="checkbox"/> Home Infusion Care (Pharmacy Lic Req)	<input type="checkbox"/> Skilled Nursing Facility
	<input type="checkbox"/> Hospice	<input type="checkbox"/> Sleep Lab
	<input type="checkbox"/> Hospital, Acute	<input type="checkbox"/> Ultrasound
	<input type="checkbox"/> Hospital (Psych & Chemical Dependency)	<input type="checkbox"/> Urgent Care Center (BCBSAZ Only)
	<input type="checkbox"/> Hospital, Rehabilitation	
	<input type="checkbox"/> Laboratory	<input type="checkbox"/> Other: _____

The completion of this form does not guarantee network participation.

**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