

## Blue Cross Blue Shield of Arizona Provider Contracting Request And Information Form

BCBSAZ and TRICARE contracting and credentialing standards require that BCBSAZ obtain, among other things, personal information, such as your name, address, and social security number. Personal information is maintained in contracting and credentialing databases at BCBSAZ for in-house tracking, reporting purposes, contracting, credentialing and payment of claims. Providing the required personal information is voluntary; however, failure to provide it will delay the contracting and credentialing process and may preclude a contract.

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

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

<b>ELECTRONIC PROVIDER : (REQUIRED)</b>	Are you an Electronic Provider? <input type="checkbox"/> Y <input type="checkbox"/> N If you answered No, please call 602-864-4844 or 1-800-656-5656.
<b>PROVIDER NAME and DEGREE:</b>	(Last) _____ (First) _____ (MI) _____ Degree (MD, DO, etc.): _____
	Gender: <input type="checkbox"/> M <input type="checkbox"/> F      DOB:    /    /    (mm/dd/yyyy)      SSN: _____
<b>Group Name (If applicable)</b>	Group Practice Name (DBA): _____
<b>TRICARE (Required if requesting participation)</b>	1099 Registered Name: _____ Patient Capacity: _____ (Tricare Primary Care Managers Only)
<b>CAQH MEMBER: : (REQUIRED)</b>	Are you participating with CAQH (Credentialing DataSource)? <input type="checkbox"/> Y <input type="checkbox"/> N      CAQH Number _____

<b>PRACTICING SPECIALTIES: (REQUIRED)</b>	<b>GYM AFFILIATION: (REQUIRED)</b>
<b>What specialty are you actively practicing?</b>  Primary: _____ Board Certified <input type="checkbox"/> Y <input type="checkbox"/> N  Secondary: _____ Board Certified <input type="checkbox"/> Y <input type="checkbox"/> N	<b>Do you provide services at a gym or fitness center?</b>  <div style="text-align: right;"><input type="checkbox"/> Y <input type="checkbox"/> N</div>

<b>NPI: : (REQUIRED)</b>	Individual NPI: _____ Eff. date: _____ / _____ / _____
PLEASE PROVIDE A COPY OF YOUR CONFIRMATION FROM NPPES	Organization NPI (if applicable): _____ Eff. date: _____ / _____ / _____
	Organization Name: _____

<b>TAXONOMY:</b>	Individual Taxonomy: _____ Organization Taxonomy: _____
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<b>LICENSE:</b>	Date first licensed to practice medicine (other than AZ): Yr: _____ State: _____
	AZ License #: _____ Date First Issued: _____ / _____ / _____

<b>OTHER ID NUMBERS:</b>	Tax ID: _____	Medicare #: _____ A <input type="checkbox"/> B <input type="checkbox"/> Eff date: _____ / _____ / _____
	<b>Date provider started billing w/tax ID:</b> _____ / _____ / _____ (REQUIRED)	DEA #: _____ Eff date: _____ / _____ / _____
		UPIN ID: _____ Eff date: _____ / _____ / _____

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

**HOSPITAL /FREE STANDING SURGERY FACILITIES PRIVILEGES: (REQUIRED)**  
**(Indicate Hospitals/Free Standing Surgery Facilities on an attached sheet)**

\_\_\_\_\_  ACTIVE  COURTESY  DELIVERY  PROVISIONAL  
 \_\_\_\_\_  ACTIVE  COURTESY  DELIVERY  PROVISIONAL  
 \_\_\_\_\_  ACTIVE  COURTESY  DELIVERY  PROVISIONAL  
 \_\_\_\_\_  ACTIVE  COURTESY  DELIVERY  PROVISIONAL

**ASC PRIVILEGES:**

**OTHER LANGUAGES SPOKEN BY PHYSICIAN (Not staff):**

1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_

<b>OFFICE CONTACT:</b>	Name: _____
	Office E-Mail Address: _____ Business Website: _____
	Phone: ( ) _____ Fax: ( ) _____

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

<b>MAILING ADDRESS:</b> (All correspondence will be sent to this address)	Street: _____ Suite: _____
	City: _____ State: _____ Zip: _____
	Phone: ( ) _____ Fax ( ) _____

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

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

The completion of this form does not guarantee network participation. Please allow approximately six weeks for the research and processing of your request and eight weeks to complete the credentialing process.

I am the \_\_\_\_\_ of \_\_\_\_\_ and authorized to submit this application on its behalf. On behalf of \_\_\_\_\_, I affirm that all of the information on this form is accurate and complete to the best of my knowledge, information, and belief.

\_\_\_\_\_ promises to keep confidential any information that BCBSAZ shares with me during this process.

Signature: \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
 (REQUIRED)

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