Contract Application/Information Form
Medical Providers

BlueCross BlueShield of Arizona

An Independent Licensee of the Blue Cross and Blue Shield Association

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) you must successfully complete the credentialing process.

Please note: Chiropractors must apply through American Specialty Health (ASH) at 1 (888) 511-2743.

REQUIRED: Professional providers are required to register with CAQH (the Council for Affordable Quality Healthcare) and complete a provider profile to be used for initial credentialing and subsequent renewals.

1. **Register with CAQH and complete your provider profile –** Register for free and complete your profile online at ProView.CAQH.org. If you practice in multiple states, be sure to specify AZ as one of them.
2. **Authorize BCBSAZ to access information** – Use the "Authorize" section in ProView to authorize BCBSAZ to access your information.
3. **Provide your CAQH provider ID number** – Enter your CAQH provider ID number in the first field of the form below.
4. **Complete the BCBSAZ application form** – Complete the entire form below and then save, attach and email the form to ProvNet@azblue.com or fax to BCBSAZ Network Management at (602) 864-3142.
5. **Update CAQH regularly** – Review, update with changes, and re-attest your CAQH provider file to keep it current.

The completion of this application/information form does not guarantee network participation. Additional documentation may be required to validate and provide detail on some responses. Providers with concierge practices must meet specific requirements and sign a Concierge Practice Contract Addendum. You have the right to review information submitted by or from other sources in support of your credentialing application, and to correct erroneous information. If you have questions regarding the contracting process, please contact Provider Network Relations at (602) 864-4231 or 1 (800) 232-2345, ext. 4231.

NOTE: Any missing items or incomplete required fields may cause significant delays.

CAQH Provider ID *(Required)*	CAQH Provider ID Number (See instructions above for CAQH registration.)			
PROVIDER NAME and DEGREE *(Required)*	Last	First	MI	Degree (MD, DO, etc.)
	Gender ☐ Male ☐ Female	Date of Birth (mm/dd/yyyy) / /	Social Security	Birth Place
OTHER NAME(S) USED	Last	First	MI	
INDIVIDUAL NPI *(Required)*	Individual NPI	Effective date (mm/dd/yyyy) / /		
LICENSE: *(Required)*	License Number	Date you were first licensed to practice in AZ (mm/dd/yyyy) / /		
OTHER ID NUMBERS *(Required)*	DEA #: _____ Expiration Date: _____/_____/_____			
	Medicare B #: _____ Effective Date: _____/_____/_____			
	UPIN ID #: _____ Effective Date: _____/_____/_____			
ARE YOU ACCEPTING NEW PATIENTS? ☐ Yes ☐ No *(Required)*				
GROUP NAME Claim payments may be made to the Group Name / NPI Number. *(Required)*	Group's Legal Name - as on file with the AZ Corporation Commission			
	Group's DBA (Doing Business As) Name - if different from above			
	Group/Organization NPI	Effective date (mm/dd/yyyy) / /		
TAX ID and START DATE *(Required)*	Tax ID Number	Date when group started billing with this tax ID # (mm/dd/yyyy) / /		

SPECIALTY / TAXONOMY Please note, what you indicate as your practicing specialty(s) will be how you are listed in the BCBSAZ Provider Directories. *(Required)*	Check applicable box: ☐ Hospital Based ☐ Office Based						
	Primary Practicing Specialty						
	Other Practicing Specialty(s), as applicable						
	Individual Taxonomy						
SPECIALTY BOARD CERTIFIED? ☐ Yes ☐ No If **YES**, please attach a copy of each Board Certificate.	Name of Specialty Board					Certificate#	
	Certified (mm/dd/yyyy) / /	Recertified (mm/dd/yyyy) / /	Expires (mm/dd/yyyy) / /				
SPECIALTY BOARD CERTIFIED? ☐ Yes ☐ No If **YES**, please attach a copy of each Board Certificate.	Name of Specialty Board					Certificate#	
	Certified (mm/dd/yyyy) / /	Recertified (mm/dd/yyyy) / /	Expires (mm/dd/yyyy) / /				
INDIAN HEALTH CARE PROVIDER *(Required)*	Are you an Indian Health Care Provider? ☐ Yes ☐ No						
OTHER LANGUAGES SPOKEN BY PHYSICIAN (Not staff)	1.	2.	3.				

HOSPITAL /FREE STANDING SURGERY FACILITIES PRIVILEGES *(Required)* If space for additional facilities is needed, please attach a separate sheet.

Facility Name:	☐ Active ☐ Courtesy ☐ Delivery ☐ Provisional
Facility Name:	☐ Active ☐ Courtesy ☐ Delivery ☐ Provisional
Facility Name:	☐ Active ☐ Courtesy ☐ Delivery ☐ Provisional
Facility Name:	☐ Active ☐ Courtesy ☐ Delivery ☐ Provisional
ASC PRIVILEGES (Facility Names):	

OFFICE CONTACT *(Required)*	Name							
	Office Contact Email Address	Phone	Fax					
BUSINESS WEBSITE *(Required)*	Website							
BUSINESS EMAIL for contracts and correspondence *(Required)*	Provider Business Email (contracts and correspondence must be sent to the provider, not to a billing company or a consultant)							
PRIMARY ADDRESS Primary address must be a physical location in Arizona, where services are performed. *(Required)*	Street Address					Suite		
	City	State	Zip					
	Phone (Patient Scheduling Number)	Fax						
	Office Hours	Sun	Mon	Tues	Wed	Thurs	Fri	Sat
	Start Time							
	End Time							

Note about Addresses: BCBSAZ sends claims payments to the provider's billing address. Unless a separate mailing address has been specified, other correspondence (including contract updates) is also sent to the billing address. An exception is Medical Records requests, which are sent to the primary location address if a separate Medical Records address is not specified.

BILLING ADDRESS Contracted provider payments will be sent to this address. *(Required)*	Street Address					Suite	
	City			State		Zip	
	Phone		Fax				
MAILING ADDRESS If no mailing address is specified, correspondence will be sent to the billing address.	Street Address					Suite	
	City			State		Zip	
	Phone		Fax				
CREDENTIALING CORRESPONDENCE If no address is specified for credentialing correspondence, it will be sent to the mailing address. If no mailing address is specified, the correspondence will be sent to the billing address.	Street Address					Suite	
	City			State		Zip	
	Phone		Fax				
MEDICAL RECORDS (If different than Primary Address)	Street Address					Suite	
	City			State		Zip	
	Medical Records Email		Phone		Fax		
ADDITIONAL OFFICE(S) for this Tax ID # Add only locations where the provider is actively practicing on a regular basis (attach an extra sheet if necessary). Do not include locations where the provider works occasionally or covers for other providers.	Please note: Claim processing for professional providers is based on NPI and tax ID number(s), not office locations.						
	Street Address					Suite	
	City			State		Zip	
	Phone		Fax		Authorization/Referral Fax		

Office Hours	Sun	Mon	Tues	Wed	Thurs	Fri	Sat
Start Time							
End Time							

Additional Information / Comments

Authorized Electronic Provider Signature: I am _____ (name and title), and I verify that the information provided on this form is current and accurate. I agree that by entering my name in the electronic signature field below, I am verifying the information as provided.

/s/_____ _____/_____/_____

Authorized Electronic Provider Signature Date

Sign, save, attach and email form to: ProvNet@azblue.com or fax to:
BCBSAZ Network Management (602) 864-3142 • Questions: (602) 864-4231

333434-17