TriWest Healthcare Alliance (Community Care Network) Contract Request and Information Form

MEDICAL PROVIDERS

BlueCross BlueShield Arizona

An Independent Licensee of the Blue Cross Blue Shield Association

Thank you for your interest in supporting our nation's military veterans by becoming contracted with the TriWest Healthcare Alliance (Community Care Network). Please ensure these required steps have been completed before sending this request form:

1. Register with CAQH at ProView.CAQH.org and complete your provider profile, including your online credentialing application.
2. Upload your supporting documentation in your CAQH profile/application. Check that your certificate of insurance (COI) is current and will not expire in the next 30 days. Mid-level providers (PAs, NPs) should include copies of professional certificates.
3. Verify your credentialing information (including your current practice address) and attest to the CAQH application.
4. Authorize BCBSAZ to access your CAQH credentialing information.
5. Complete all required fields on this form, sign it, and return it along with required documentation to BCBSAZ Provider Partnerships at ProvNet@azblue.com.

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

CONTACT PERSON *(Required)*	Name of contact person for questions related to this request and credentialing information		
	Best way to contact you:	Phone ☐	Email ☐

BCBSAZ will notify the above contact person of any incomplete or missing information. If the required information is not received within 30 days, your request will be withdrawn and you will need to resubmit it for consideration.

PROVIDER INFORMATION				
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,ect.)
	Gender	Date of birth	Social Security	
	Male ☐ Female ☐	/ /	- -	
OTHER NAME(S) USED	Last	First	MI	
INDIVIDUAL NPI *(Required)*	Individual NPI	Effective Date (mm/dd/yyyy)		
		/ /		
TAXONOMY CODE *(Required)*	Taxonomy Code	Effective Date (mm/dd/yyyy)		
		/ /		
TAX ID *(Required)*	Tax ID Number (Employer Identification Number)	Date when provider started billing with this tax ID# (mm/dd/yyyy)		
		/ /		
LICENSE *(Required)*	License Number	Date when provider started billing with this tax ID# (mm/dd/yyyy)		
		/ /		
DEA REGISTRATION *(Required)*	DEA Registration Number	Expiration date		
		/ /		
SPECIALTY *(Required)* Please note, what you indicate as your practicing specialty(s) will be how you are listed in the BCBSAZ provider directories.	Check applicable box: Hospital Based ☐ Office Based ☐			
	Primary Practicing Specialty	Are you practicing as a PCP under the above tax ID?		
		Yes ☐ No ☐		
	Other Practicing Specialty(s), as applicable			
	Are you certified for medication assisted treatment (MAT) for substance use disorders? Yes ☐ No ☐			
INDIAN HEALTH SERVICES PROVIDER *(Required)*	Are you an Indian Health Service Provider with the Federal Health Program for American Indians and Alaska Natives?			
	Yes ☐ No ☐			
MEDICARE ADVANTAGE *(Required)*	Are you interested in practicing in our Medicare Advantage networks?			
	Yes ☐ No ☐			

OTHER LANGUAGES SPOKEN BY PHYSICIAN (not staff)	1.	2.	3.

ARE YOU ACCEPTING NEW PATIENTS? *(Required)* this information will not be noted in our provider directories. Yes ☐ No ☐

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 ☐
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ASC PRIVILEGES (Facility Names):

GROUP INFORMATION *(Required)*
Claim payments may be made to the Group Name / NPI Number

Group's Legal Name – as on file with the AZ Corporation Commission	Entity ID # (AZ Corp Commission)

Group's DBA (Doing Business As) Name – if different from above

Group/Organization NPI	Effective Date (mm/dd/yyyy)
	/ /

Does this group have a concierge practice?

Yes ☐ No ☐

To comply with BCBSAZ contractual obligations, providers with concierge practices must meet specific requirements and sign a Concierge Pratice Contract Addendum. For more information, please email cred@azblue.com.

A "concierge" medical practice is one in which the patient pays an annual fee or retainer for enhanced services not otherwise available from a provider. The concierge arrangement is typically documented in a written concierge agreement between the provider and the patient.

OFFICE CONTACT PERSON *(Required)*

Name of contact person for the practice (practice administrator/office manager) for business correspondence

Email	Phone	Fax

BUSINESS WEBSITE *(Required)*

Website

BUSINESS EMAIL *(Required)*
for contracts and correspondence

Provider Business Email (contracts and correspondence must be sent to the provider, not to a billing company or a consultant)

PRIMARY ADDRESS *(Required)*
Primary address must be a physical location in Arizona, where services are performed.

Street Adress	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
(Required)
Contracted provider payments will be sent to this address.

Same as primary address: Yes ☐ No ☐

Street Adress		Suite
City	State	ZIP
Phone (Patient Scheduling Number)		Fax

MAILING ADDRESS
If no mailing address is specified, correspondence will be sent to the billing address.

Same as billing address: Yes ☐ No ☐

Street Adress		Suite
City	State	ZIP
Phone (Patient Scheduling Number)		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.

Same as mailing address: Yes ☐ No ☐ Same as biling address: Yes ☐ No ☐

Street Adress		Suite
City	State	ZIP
PCredentialing Correspondence Email	Phone	Fax

MEDICAL RECORDS
(If different than primary address)

Same as primary address: Yes ☐ No ☐

Street Adress		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 Adress		Suite
City	State	ZIP
Phone (Patient Scheduling Number)	Fax	Authorization/Referral Fax

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

ADDITIONAL INFORMATION / COMMENTS

Authorized Electronic Provider Signature *(Required)*

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, and email completed form with all required documentation to ProvNet@azblue.com or fax to: BCBSAZ Provider Partnerships at 602-864-3125
Questions: 602-864-4231

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