Contract Application/Information Form
Facility & Ancillary 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: If you are a professional group, please use the *Contract Application/Information Form-Medical.***

BCBSAZ credentialing and contracting standards require the collection of information such as facility name, physical address and tax ID#. Confidential information is maintained in contracting and credentialing systems at BCBSAZ for in-house tracking, reporting purposes, and payment of claims.

In addition to the information on this form, supporting documentation is required:

- A copy of the facility's ADHS (Arizona Department of Health Services) License
- A copy of the facility's Professional Liability (Malpractice) Insurance Certificate
- For DME / Medical Supply facilities, a copy of the current product list

Please complete all pages of this form in full, then save, attach and email it along with supporting documentation to ProvNet@azblue.com or fax to BCBSAZ Network Management at (602) 864-3142.

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. 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.

FACILITY NAME *(Required)*	Facility's Legal Name - as on file with the AZ Corporation Commission		
	Facility's DBA (Doing Business As) Name - if different from above		
FACILITY NPI *(Required)*	Facility NPI *(Please indicate the NPI used for the primary service location.)*		Effective date (mm/dd/yyyy) / /
TAX ID and START DATE *(Required)*	Tax ID	Start date (mm/dd/yyyy) when this facility started billing with this tax ID# / /	
FACILITY OWNERSHIP (if different from Facility Name)	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 legal name of the organization(s), as on file with the AZ Corporation Commission		
	If your organization has experienced a recent change in ownership, please list current and previous owners, along with dates of change and previous tax ID or NPI number(s)		

LICENSE INFORMATION *(Required)* Please include with your application a current copy of the facility's ADHS (Arizona Department of Health Services) License.

AZ License #	License Type	Facility Open Date (mm/dd/yyyy)
		/ /

Date License First Issued (mm/dd/yyyy)	Expiration Date (mm/dd/yyyy)	Name as it appears on the License
/ /	/ /	

Medicare Certified?	Medicare A #	Effective date (mm/dd/yyyy)
☐ Yes ☐ No		/ /

ACCREDITATION INFORMATION

Is your facility currently accredited? ☐ Yes ☐ No

If yes, please indicate by checking the appropriate accrediting organization. *(Please attach evidence of current accreditation.)*

☐ AAAASF	☐ AASM	☐ ADA	☐ CARF	☐ IAC
☐ AAAHC	☐ ACHC	☐ AOA (HFAP)	☐ CHAP	☐ KePro
☐ AADE	☐ ACR	☐ CABC	☐ DNV	☐ TJC (JCAHO)

Other Accreditation *(please specify)*

INSURANCE INFORMATION *(Required)* A current copy of the facility's certificate of Professional Liability insurance must be included with this form (see note for details).

Specific insurance requirements: The facility's Professional Liability (Malpractice) insurance must have 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

Policy Number	Expiration (mm/dd/yyyy)
	/ /

PRIMARY SPECIALTY *(Required)* Check the one most applicable for the facility/entity.

- ☐ Ambulance Company-Air
- ☐ Ambulance Company-Ground
- ☐ Ambulatory Surgery Center (ASC) - includes Cardiac Cath Labs and >24-hours Recovery Care
- ☐ Behavioral Health outpatient programs (example: Partial Hospitalization Program)
- ☐ Behavioral Health, Sub Acute (example: Residential Treatment Center, Rehab Treatment Center)
- ☐ Birthing Center
- ☐ Diabetic Education and Training (Note: Must have ADA Accreditation)
- ☐ Dialysis
- ☐ DME / Medical Supply (Current product list required)
- ☐ Extended Active Rehabilitation (EAR)
- ☐ FQHC (Federally Qualified Health Center)
- ☐ Hearing Aid Dispenser
- ☐ Home Health Agency
- ☐ Home Infusion Care (Facility must have pharmacy license and offer in-home nursing services. Check below to verify.)
  - ☐ Valid pharmacy license ☐ In-home nursing services are offered
- ☐ Hospice
- ☐ Hospital, Acute Care
- ☐ Hospital, Long Term Acute Care
- ☐ Hospital, Psychiatric
- ☐ Infusion Center (outpatient)
- ☐ Laboratory
- ☐ Orthotics
- ☐ Prosthetics
- ☐ Radiology Center (Check all that apply)
  - ☐ CT ☐ X-Ray ☐ MRI ☐ PET ☐ Mammography
  - ☐ Ultrasound (Note: Must have ACR Accreditation for CT, MRI, and PET)
- ☐ Skilled Nursing Facility
- ☐ Sleep Lab
- ☐ Specialty Pharmacy (Facility must have pharmacy license and be able to ship to a patient's home. Check below to verify.)
  - ☐ Valid pharmacy license ☐ Able to ship to patient's home
- ☐ Urgent Care Center

INDIAN HEALTH CARE PROVIDER *(Required)*

Are you an Indian Health Care Provider?

☐ Yes ☐ No

OFFICE CONTACT for FACILITY/ENTITY *(Required)*

Name	Office Contact Email Address

Office Contact Email Address	Phone	Fax

BUSINESS WEBSITE *(Required)*

Website

BUSINESS EMAIL for contracts and correspondence *(Required)*

Facility Business Email (Contracts and correspondence must be sent to the facility, not to a billing company or a consultant.)

Please submit a separate form for each additional location.

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.

PRIMARY ADDRESS Physical location where services are performed *(Required)*	Street Address						Suite	
	City				State		Zip	
	Is this a change in location? ☐ Yes ☐ No	If yes, when did the location change? mm/dd/yyyy / /		If yes, address of previous location to be deleted from the BCBSAZ database?				
	Phone (main contact number)			Fax				
	Office Hours	Sun	Mon	Tues	Wed	Thurs	Fri	Sat
	Start Time							
	End Time							
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				
	Email							
MEDICAL RECORDS (If different than Primary Address)	Street Address						Suite	
	City				State		Zip	
	Phone			Fax				

ADDITIONAL INFORMATION / COMMENTS

Read, sign and date the Release and Attestation on the next page. ***(Required)***

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.

The completion of this request form does not guarantee network participation. You will be notified after your request has been researched and processed for credentialing.

Authorized Electronic Signature:

I am _____ (name and title), and I verify that I am authorized to submit this application form on behalf of the facility/entity, ancillary provider, or facility/entity/provider's agent. I agree that by entering my name in the electronic signature field below, I am verifying the information as provided.

/s/_____ _____

Authorized Electronic Signature Date

Authorized representative of: _____

Institution/Entity

Sign, save, attach and email ENTIRE FORM along with required documentation to ProvNet@azblue.com or fax to BCBSAZ Network Management at (602) 864-3142

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