Contract Request and Information Form
FACILITY, GROUP, & ANCILLARY PROVIDERS

BlueCross BlueShield Arizona

An Independent Licensee of the Blue Cross Blue Shield Association

Use this form to request (or update) a contract for a facility, professional group, or ancillary provider. To request a contract or credentialing for an individual professional provider, please use the *Contract Request/Information Form-Medical*.

Confidential information collected through our contracting and credentialing process is maintained in BCBSAZ systems for in-house tracking, reporting purposes, and payment of claims. Please ensure the following documentation is submitted with this form:

- 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 your current product list
- Copies of other licenses and accreditations as detailed on page 2 of this form

The completion of this request/information form does not guarantee network participation. Additional documentation may be required to complete the credentialing process. You have the right to review information submitted by or from other sources in support of your credentialing application, and to correct any errors.

After completing all required fields of this form, save, attach, and email it along with the required documentation to Cred@azblue.com or fax to BCBSAZ Credentialing at 602-864-3125. *You must submit a separate form for each additional location.*

CONTACT PERSON *(Required)*	Name of contact person for questions related to this application and/or credentialing		
	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 If the required information is not received within 30 days, your request will be withdrawn and you will need to re-submit it for consideration.

FACILITY INFORMATION			
FACILITY NAME *(Required)*	Facility's Legal Name - as on file with the AZ Corporation Commission		Entity ID # (AZ Corp Commission)
	Facility's DBA (Doing Business As) Name - if different from above		
FACILITY NPI *(Required)*	Facility NPI *(Indicate the NPI used for the primary service location.)*		Effective date (mm/dd/yyyy)
			/ /
TAXONOMY CODE *(Required)*	Taxonomy Code		Effective date (mm/dd/yyyy)
			/ /
TAX ID *(Required)*	Tax ID		Date when facility started billing with this tax ID # (mm/dd/yyyy)
			/ /
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, 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, list current and previous owners, along with dates of change and previous tax ID or NPI number(s)		
LICENSE INFORMATION *(Required)* Send with this form (as applicable): • Copy of AZ License • Copy of Medicare Certification.	AZ License # (include copy)	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? (if yes, include copy)	Medicare A #	Effective Date (mm/dd/yyyy)
	☐ Yes ☐ No		/ /

ACCREDITATION INFORMATION
Send with this form: A copy of the facility's current accreditation(s).

Is your facility currently accredited? ☐ Yes ☐ No

If yes, indicate by checking the appropriate accrediting organization(s). *(Send copy of current accreditation with this form.)*

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

Other Accreditation *(please specify)*

INSURANCE INFORMATION
(Required) Send with this form: A copy of the facility's current certificate of professional liability insurance (must meet specific insurance requirements).

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 all that are applicable for the facility/entity. Send with this form (as applicable):
- Copy of ADA Accreditation
- Current DME/ Medical Supply product list
- Copy of Pharmacy License
- Copy of ACR Accreditation

☐ Ambulance Company - Air
☐ Ambulance Company - Ground
☐ Ambulatory Surgery Center (ASC) - includes Cardiac Cath Labs and >24-hours Recovery Care
☐ Behavioral Health Outpatient Programs
  ☐ Adult ☐ Child/Adolescent ☐ Eating Disorders
☐ Behavioral Health, Sub Acute (example: Residential Treatment Center, Rehab Treatment Center)
☐ Birthing Center
☐ Diabetic Education and Training (ADA Accreditation required. Send copy of current accreditation with this form.)
☐ Dialysis
☐ DME/Medical Supply; product list required; send copy of current list with this form. (Check all that apply)
  ☐ Breast Pumps
  ☐ Diabetic Pumps/Supplies
  ☐ Respiratory/Oxygen
  ☐ Mobility/Wheel Chairs
  ☐ Urinary/Ostomy
  ☐ General DME
☐ Extended Active Rehabilitation (EAR)
☐ FQHC (Federally Qualified Health Center)
☐ Hearing Aid Dispenser
☐ Home Health Agency
☐ Home Infusion Care (Pharmacy license required. Must offer in-home nursing services. Check below to verify. Send copy of license with this form.)
  ☐ Valid pharmacy license ☐ In-home nursing services are offered
☐ Hospice
☐ Hospital, Acute Care
☐ Hospital, Long-Term Acute Care
☐ IDTF/Cardiac/Other Monitoring
☐ Hospital, Psychiatric
☐ Infusion Center (outpatient)
☐ Laboratory
☐ Orthotics
☐ Physical Therapy & Rehabilitation (PT/ST/OT)
☐ Prosthetics
  Do you supply cochlear implants? ☐ Y ☐ N
  Do you supply other prosthetics? ☐ Y ☐ N
☐ Radiology Center (Check all that apply)
  ☐ CT ☐ X-ray ☐ MRI ☐ PET ☐ Mammography
  ☐ Ultrasound (ACR Accreditation required for CT, MRI, and PET. Send copy of current accreditation with this form.)
☐ Skilled Nursing Facility
☐ Sleep Lab
☐ Specialty Pharmacy (Pharmacy license required. Must be able to ship to a patient's home. Check below to verify. Send copy of license with this form.)
  ☐ Valid pharmacy license ☐ Able to ship to patient's home
☐ Urgent Care Center
☐ Substance Use Disorder Programs - Inpatient/Outpatient (Check all that apply):
  ☐ Recovery Care
  ☐ Residential
  ☐ Residential-Child/Adolescent

INDIAN HEALTH CARE PROVIDER
(Required)

Are you an Indian Health Care Provider?

☐ Yes ☐ No

BUSINESS CONTACT for FACILITY/ENTITY
(Required)

Name of facility/entity contact person for business correspondence

Email	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)

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?	If yes, when did the location change? mm/dd/yyyy		If yes, address of previous location to be deleted from the BCBSAZ database?				
☐ Yes ☐ No	/ /						
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), _____ (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 all required documentation to Cred@azblue.com or fax to BCBSAZ Credentialing at 602-864-3125

If you have any questions regarding the contracting and credentialing process, please contact **Provider Network Relations at 602-864-4231 or 1-800-232-2345.**

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