

Contract Request and Information Form

MEDICAL PROVIDERS



An Independent Licensee of the Blue Cross Blue Shield Association

Thank you for your interest in becoming a Blue Cross® Blue Shield® of Arizona (BCBSAZ) network provider. 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 Credentialing at Cred@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 <i>(Required)</i>	Name of contact person for questions related to this request and credentialing information		
	Best way to contact you:	Phone <input type="checkbox"/>	Email <input type="checkbox"/>

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 If the required information is not received **within 30 days**, your request will be withdrawn and you will need to resubmit it for consideration.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 <i>(Required)</i>	CAQH Provider ID Number (See instructions above for CAQH registration.)		
PROVIDER NAME and DEGREE <i>(Required)</i>	Last	First	MI Degree (MD,DO,ect.)
	Gender Male Female	Date of birth / /	Social Security - -
OTHER NAME(S) USED	Last	First	MI
INDIVIDUAL NPI <i>(Required)</i>	Individual NPI	Effective Date (mm/dd/yyyy)	
		/ /	
TAXONOMY CODE <i>(Required)</i>	Taxonomy Code	Effective Date (mm/dd/yyyy)	
		/ /	
TAX ID <i>(Required)</i>	Tax ID Number (Employer Identification Number)	Date when provider started billing with this tax ID# (mm/dd/yyyy)	
		/ /	
LICENSE <i>(Required)</i>	License Number	Date when provider started billing with this tax ID# (mm/dd/yyyy)	
		/ /	
DEA REGISTRATION <i>(Required)</i>	DEA Registration Number	Expiration date	
		/ /	
SPECIALTY <i>(Required)</i> 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 <input type="checkbox"/> Office Based <input type="checkbox"/>		
	Primary Practicing Specialty	Are you practicing as a PCP under the above tax ID?	
		Yes <input type="checkbox"/> No <input type="checkbox"/>	
	Other Practicing Specialty(s), as applicable		
	Are you certified for medication assisted treatment (MAT) for substance use disorders? Yes <input type="checkbox"/> No <input type="checkbox"/>		
INDIAN HEALTH SERVICES PROVIDER <i>(Required)</i>	Are you an Indian Health Service Provider with the Federal Health Program for American Indians and Alaska Natives?		
	Yes <input type="checkbox"/> No <input type="checkbox"/>		
MEDICARE ADVANTAGE <i>(Required)</i>	Are you interested in practicing in our Medicare Advantage networks?		
	Yes <input type="checkbox"/> No <input type="checkbox"/>		

OTHER LANGUAGES SPOKEN BY PHYSICIAN (not staff)	1.	2.	3.					
ARE YOU ACCEPTING NEW PATIENTS? <i>(Required)</i> this information will not be noted in our provider directories. Yes <input type="checkbox"/> No <input type="checkbox"/>								
HOSPITAL / FREE-STANDING SURGERY FACILITIES PRIVILEGES <i>(Required)</i> If space for additional facilities is needed, please attach a separate sheet.								
Facility name:		Active <input type="checkbox"/> Courtesy <input type="checkbox"/> Delivery <input type="checkbox"/> Provisional <input type="checkbox"/>						
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ASC PRIVILEGES (Facility Names):								
GROUP INFORMATION <i>(Required)</i> 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 <input type="checkbox"/> No <input type="checkbox"/>								
To comply with BCBSAZ contractual obligations, providers with concierge practices must meet specific requirements and sign a Concierge Practice Contract Addendum. For more information, please email cred@azblue.com.								
<i>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.</i>								
OFFICE CONTACT PERSON <i>(Required)</i>	Name of contact person for the practice (practice administrator/office manager) for business correspondence							
	Email	Phone	Fax					
BUSINESS WEBSITE <i>(Required)</i>	Website							
BUSINESS EMAIL <i>(Required)</i> 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 <i>(Required)</i> Primary address must be a physical location in Arizona, where services are performed.	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 <i>(Required)</i> Contracted provider payments will be sent to this address.	Same as primary address: Yes <input type="checkbox"/> No <input type="checkbox"/>							
	Street Address						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 <input type="checkbox"/> No <input type="checkbox"/>							
	Street Address						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 <input type="checkbox"/> No <input type="checkbox"/>				Same as billing address: Yes <input type="checkbox"/> No <input type="checkbox"/>			
	Street Address						Suite	
	City			State			ZIP	
	PCredentialing Correspondence Email			Phone			Fax	
MEDICAL RECORDS (If different than primary address)	Same as primary address: Yes <input type="checkbox"/> No <input type="checkbox"/>							
	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 (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 Cred@azblue.com
or fax to: BCBSAZ Credentialing 602-864-3125 • Questions: 602-864-4231**