

Blue Cross Blue Shield of Arizona Facility/Ancillary Request for Contracting and Information Form

BCBSAZ and TRICARE contracting and credentialing standards require that BCBSAZ obtain, among other things, personal information, such as your name, address, and social security number. Personal information is maintained in contracting and credentialing databases at BCBSAZ for in-house tracking, reporting purposes, contracting, credentialing and payment of claims. Providing the required personal information is voluntary; however, failure to provide it will delay the contracting and credentialing process and may preclude a contract.

IN ORDER TO BE CONTRACTED, YOU MUST HAVE AN NPI AND SUBMIT CLAIMS ELECTRONICALLY. TO CONTINUE PROCESSING, ALL REQUIRED FIELDS MUST BE COMPLETED.

I am requesting: BCBSAZ Participation TRICARE Participation (copy of W9 required)

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| Electronic Provider: (REQUIRED) | Are you an Electronic Provider? <input type="checkbox"/> Y <input type="checkbox"/> N If you answered No, please call 602-864-4844 or 1-800-656-5656. | |
| Corporate Name: | Facility/Ancillary Name: _____ Provider Name (If different): _____ | |
| Administrative Contact: | Contact Name: _____ Office Email Address: _____ Phone Number: (____) _____ Fax Number: (____) _____ | |
| NPI: (REQUIRED) Please provide a copy of your NPI confirmation from NPPES | Organization NPI: _____ Eff. date: ____/____/____ Organization Name: _____ Individual NPI(if applicable): _____ Eff. date: ____/____/____ | |
| Taxonomy: | Organization Taxonomy: _____ Individual Taxonomy: _____ | |
| Tax ID: (REQUIRED) Secondary ID's: | Tax ID #: _____ Date provider started billing w/tax ID: ____/____/____ (REQUIRED) | Medicare #: _____ A <input type="checkbox"/> B <input type="checkbox"/> Eff date: ____/____/____ DEA #: _____ Eff date: ____/____/____ UPIN ID: _____ Eff date: ____/____/____ |
| License: | Practice Open Date: ____/____/____ AZ License #: _____ Date First Issued: ____/____/____ Exp Date: ____/____/____ | |
| Facility Specialties: Check only one | <input type="checkbox"/> Hospital, Acute <input type="checkbox"/> Hospital, Psychiatric <input type="checkbox"/> Hospital, Rehabilitation <input type="checkbox"/> Home Health Agency <input type="checkbox"/> Infusion Therapy <input type="checkbox"/> Hospital Long Term Acute <input type="checkbox"/> Skilled Nursing <input type="checkbox"/> Hospice <input type="checkbox"/> Urgent Care Facility <input type="checkbox"/> Surgery Center <input type="checkbox"/> Dialysis <input type="checkbox"/> VA, DOD, HIS | |
| Ancillary Specialties: Check all that apply | REQUIRED: INCLUDE A COPY OF YOUR CERTIFICATE OF INSURANCE WITH SUBMISSION (if applicable)** <input type="checkbox"/> Laboratory <input type="checkbox"/> Radiology Center <input type="checkbox"/> Prosthetics <input type="checkbox"/> Air Ambulance <input type="checkbox"/> Optical Establishment <input type="checkbox"/> DME <input type="checkbox"/> Therapy, PT/OT <input type="checkbox"/> Therapy, ST <input type="checkbox"/> Orthotics <input type="checkbox"/> Ground Ambulance <input type="checkbox"/> Dispensing Optician | |

