For Internal Use Only *(Individual Application)*		
Internal #:	**Reason:**	New Provider

Provider Information Change Form

I. PERSONAL INFORMATION

Name: ____ Gender: M or F Date of Birth:___/___/____
First Middle Last Suffix Degree (MD,RN, etc.) (Circle One) MM / DD / YY

BCBST Provider Number:_______________________ NPI Number:________________________ Group NPI Number:________________________

Medicare Provider Number:___________________________ Medicaid Provider Number:____

Tax ID:____ Social Security Number: ____
(Required) (Required)
(Tax Coupon booklet, Online Snapshot or 147C Letter from the IRS Required for Tax Change)

State Lic. #____________ DEA #______________ UPIN #____________ Type of Provider: PCP______ Specialist______ Other______

Specialty: Primary Language Spoken: ______________________Secondary Language Spoken:_________________

Race / Ethnicity *(Optional*)*		
☐ Asian	☐ Black (not Hispanic) or African-American	☐ Pacific Islander
☐ Asian American	☐ Hispanic	☐ White (not Hispanic)
☐ Alaska Native	☐ North American Indian	☐ Other (please specify)________________

*While this section is optional, we ask that you complete for accreditation purposes and to maintain a comprehensive provider directory.

II. LOCATION INFORMATION

Do you currently work for an Outpatient Diagnostic Facility? ☐ Yes ☐ No

Primary Location Information			
Practice/Group Name:		Pay To: ☐ Self ☐ Group	
Start Date at Location (Required):			
Address:	City:	State: Zip:	*E-mail address:
Phone: ( ) - Ext:	Fax: ( ) -	After Hours:: ( ) - Ext:	Web site address::
Contact Information: Name:	Title:	Phone: ( ) -	Ext:

*This email address will be used to communicate important information. It is your responsibility to notify BCBST of any changes to the address

Office Hours
(If this section is left blank, office hours will default to M-F 8am to 5pm)

Time Zone	☐ Central Time	☐ Eastern Time	**From**	**To**	**From**	**To**
Monday	☐ Closed					
Tuesday	☐ Closed	☐ Same as Monday				
Wednesday	☐ Closed	☐ Same as Monday				
Thursday	☐ Closed	☐ Same as Monday				
Friday	☐ Closed	☐ Same as Monday				
Saturday	☐ Closed	☐ Same as Monday				
Sunday	☐ Closed	☐ Same as Monday				

Handicap accessible?	**Hospital Based Prov?**	**24-hour coverage?**	**Concierge Provider?**
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Patient Accepting Status	**Accepting Patients for Networks P, S, or V?**
☐ New and Existing ☐ Existing Only* (*Note: You must be closed to all payers)	☐ Yes ☐ No

III. ADDITIONAL LOCATION INFORMATION

If you need additional locations, make copies of this page.

Additional Location Information			
☐ Add Location ☐ Change Contact Information ☐ Remove Location			
Address:	City:	State: Zip:	*E-mail address:
Phone: ( ) - Ext:	Fax: ( ) -	Web site address::	
Handicap accessible?	**Patient Accepting Status**	**24-hour coverage?**	
☐ Yes ☐ No	☐ New and Existing ☐ Existing* (*Note: You must be closed to all payers)	☐ Yes ☐ No	
Contact Information:	Name:	Title:	Phone: ( ) - Ext:

Additional Location Information			
☐ Add Location ☐ Change Contact Information ☐ Remove Location			
Address:	City:	State: Zip:	*E-mail address:
Phone: ( ) - Ext:	Fax: ( ) -	Web site address::	
Handicap accessible?	**Patient Accepting Status**	**24-hour coverage?**	
☐ Yes ☐ No	☐ New and Existing ☐ Existing* (*Note: You must be closed to all payers)	☐ Yes ☐ No	
Contact Information:	Name:	Title:	Phone: ( ) - Ext:

IV. ADDRESS INFORMATION

Mailing Address		
☐ Add Location ☐ Change Location ☐ Remove Location		
☐ Same as primary ☐ Other (Please specify)	Address:	City: State: Zip:
	Phone: ( ) - Ext:	Fax: ( ) -
Effective Date of Address change:_________________		
Corporate Address		
☐ Add Location ☐ Change Location ☐ Remove Location		
☐ Same as primary ☐ Other (Please specify)	Address:	City: State: Zip:
	Phone: ( ) - Ext:	Fax: ( ) -
Effective Date of Address change:_________________		
Pay To Address		
☐ Add Location ☐ Change Location ☐ Remove Location		
☐ Same as primary ☐ Other (Please specify)	Address:	City: State: Zip:
	Phone: ( ) - Ext:	Fax: ( ) -
Effective Date of Address change:_________________		

V. PCP AND PHYSICIAN EXTENDERS INFORMATION ONLY

Practice Status:	☐ PCP	☐ Physician Extender (Applicable to PAs, PAs at Surgery, and NP)	☐ Specialist
Preceptor Information:	Not Applicable	**Full Name** 1. 2. 3.	**Provider Number** 1. 2. 3.

Please enter the maximum number of patients you will accept for the following networks.		
BlueCare **TennCareSelect**		
BPN		
Select Community		
Total Patients	The three networks listed above can combine to a maximum of 1500 patients.	The three networks listed above can combine to a maximum of 1250 patients.

Please indicate below what, if any, patient age and gender limitations you have set for your practice.

Patients Sex:	☐ Male Only ☐ Female Only ☐ Both Male and Female	**Patients Age:**	☐ Adult only (Ages 18 years and above) ☐ Pediatric Only (Ages 0-17 years) ☐ Both Adult and Pediatric (No age limitations)
Other Limitations (Please Specify)			

Please indicate below if any of the services below are offered.

☐ Pre-Natal Care ☐ Accepts Presumptive Eligibles ☐ OB Services

VI. ADMITTING PRIVILEGES

Do you have admitting privileges with a BlueCross BlueShield of Tennessee network hospital?

List all institutions where you CURRENTLY have clinical privileges.*

	Primary Institution	**Secondary Institution**
Name of Institution:		
Address:	Address: City: State: Zip:	Address: City: State: Zip:
Appointment Date:	(mm/yy)	(mm/yy)
Status:	☐ Active/Admitting ☐ Courtesy ☐ Other ☐ Associate ☐ Provisional ________	☐ Active/Admitting ☐ Courtesy ☐ Other ☐ Associate ☐ Provisional ________

*This includes hospitals, surgery centers, institutions, corporations, military assignments, or government agencies. If more space is needed, attach additional sheet(s).

If you do not hold admitting or clinical privileges

List the name(s) of the practitioner(s) who admits your patients.*

Practitioner Name	**Specialty**	**Phone**
1.		( ) - Ext:
2.		( ) - Ext:
3.		( ) - Ext:

*Admitting or clinical privileges must be provided by a BlueCross BlueShield of Tennessee credentialed practitioner.You must attach a letter on admitting practitioner's letterhead that certifies this practitioner will admit your patients.

Please provide the full name and BCBST provider or NPI number of your covering physician(s). If you need additional space, please list providers on a separate sheet and attach.

On-Call Provider Name	BCBST Provider Number	NPI	BCBST Networks

VII. PROVIDER LEAVING PRACTICE/GROUP

Reason for Leaving: (Select one option below)

☐ Moved out of state	☐ Tax Change	☐ Retired
☐ Deceased	☐ No longer practice at this location	☐ Other:______________________________

Effective date of reason listed above:_______________________________

Primary Care Physician

Please advise how to transition any members currently assigned to you.

(Please note Members can only be transitioned to a new location that provides access to care within 30 miles or 30 minutes travel time)

☐ Automatically assign to another BlueCross provider		
☐ Transfer members to my other location	BlueCross Provider # _____________ NPI #___________________________ Tax Id__________________________	Address____ City_____________________ ST______ Zip____________
☐ Assign my members to the following provider number(s)	BlueCross Provider # _____________ NPI #___________________________ Tax Id__________________________	Address____ City_____________________ ST______ Zip____________
**Provider must be a participating BCBST Primary Care provider in the network in which members are assigned.	BlueCross Provider # _____________ NPI #___________________________ Tax Id__________________________	Address____ City_____________________ ST______ Zip____________
	BlueCross Provider # _____________ NPI #___________________________ Tax Id__________________________	Address____ City_____________________ ST______ Zip____________

The current PCP must sign this form indicating authorization to reassign members.

______________________________ ___________
Current PCM Date

In order for member to be transferred to a specific PCP, the PCP agreeing to accept the member must sign below.

______________________________ ___________
PCP agreeing to accept members Date

If the provider has left and there is no forwarding information to contact the provider, the Office Manager can authorize the transition of members by signing below:

_____________________________________ _______________
Office Manager Date

BLUECROSS BLUESHIELD OF TENNESSEE AND VOLUNTEER STATE HEALTH PLAN, INC. ATTESTATION

I authorize BlueCross BlueShield of Tennessee, Inc. (BCBST) to consult with hospital administrators, physicians, current and prior malpractice carriers, managed health care plans, IPAs, medical groups and other persons or entities (hereafter collectively referred to as "Persons") to obtain and verify information concerning: my professional competence and conduct, including any pending or closed claims, settlements or judgments against me; character, moral and ethical qualities; and experience in participating in managed care programs (my "Qualifications"). I release BCBST and any such Person and their respective directors, officers, employees, agents or contractors (their "Representative") from any and all liability for any and all acts or omissions arising from or related to the provision, receipt, verification, or evaluation of information pertaining to my Qualifications; except to the extent that such information is knowingly false or misleading and is provided in bad faith or with malice. I acknowledge that my Qualifications shall be evaluated by, or at the direction of BCBST's medical review committee in accordance with TCA 63-6-219.

I represent that the information provided in or attached to this Application and the most current information provided to the selected entities is accurate and complete. I understand that a condition of this Application is that any misrepresentation, misstatement or omission from this Application, whether intentional or not, is cause for automatic and immediate rejection of this Application by the selected entities and may result in denial of my Application or termination of my participation with BCBST. I further understand that any misrepresentation, misstatement or omission from this Application, if discovered after participation has been awarded to me, may lead to immediate suspension or termination of those privileges.

I hereby authorize BCBST to query the National Practitioner Data Bank (NPDB) and the Healthcare Integrity and Protection Data Bank (HIPDB) and further release BCBST from any and all liability arising from querying and reporting to the HIPDB as required by 45 CFR Part 61, except to the extent BCBST has actual knowledge of the falsity of the reported information. I further agree that any dispute relating to or arising in connection with this Application must be resolved in accordance with applicable BCBST policies and procedures.

I consent to such Persons releasing all information and documents that may be relevant to an evaluation of my Qualifications, to BCBST, including, without limitation, information or documents relating to any disciplinary action, suspension or curtailment of my medical license or privileges; and reports or summaries by professional liability insurance carriers or others relating to my insurance coverages, pending and /or closed legal actions, and/or professional liability settlements by or judgments against me. If I have contracted with an IPA, a medical group, physician/hospital organization or similar entity (an "Intermediary"), through which I will participate in BCBST's provider network(s), that Intermediary may disclose all requested information concerning my Qualifications to BCBST. If the Intermediary with whom I have contracted has contracted with another entity to obtain or verify information concerning my Qualifications, that entity and BCBST may consult with and disclose such information to each other.

If any material changes occur with affect my Qualifications, specifically including changes in the information set forth in this application, I agree to immediately notify BCBST of such changes. I understand that I have the burden of providing adequate information to BCBST to demonstrate my Qualifications both now and in the future. I acknowledge that BCBST may, at its sole discretion, decline to contract with me. I agree that any dispute related to or arising in connection with this application must be resolved in accordance with applicable BCBST policies and procedures. This consent shall remain in full force and effect and may be relied on by those Persons and Intermediaries providing information to BCBST until I specifically revoke it in writing. Any such revocation shall not apply retrospectively. A photocopy of this Consent shall be as effective as the original.

No person on the grounds of race, color, religion, national origin, sex, age, or disability shall be excluded form participation in or be subjected to discrimination under any program or service provided by Blue Cross Blue Shield of Tennessee, Inc or Volunteer State Health Plan, Inc.

Name: ____ SSN:_______________________________________

Physician Name Only

Signature: ____ Date:_______________________________________

Physician Signature Required

*Please note that original signature is required here. A signature stamp or any other means of signing is unacceptable.

Please fax to: (423) 535-6711 or mail to: BlueCross BlueShield of Tennessee
Attn: Provider Network Services
One Cameron Hill Circle Suite 0007
Chattanooga, TN 37402-0007