Medical Group Contract Form

BlueCross BlueShield Arizona

An Independent Licensee of the Blue Cross Blue Shield Association

If your group is new to the AZ Blue network (your tax ID is not yet under contract with us), you may use this form to request a group contract. To be eligible, your group must include five or more providers. Before we can finalize your contract, at least one practitioner must be credentialed with AZ Blue, and all others must be on track to complete credentialing.
Note: We do not accept this request form for groups with a tax ID already under contract with AZ Blue.

This request applies to (check one or both): ☐ AZ Blue Network Participation ☐ TriWest Healthcare Alliance Networks Participation			
CONTACT PERSON FOR THIS REQUEST *	Name of contact person for questions related to this request		
	Best way to contact you:	☐ Phone	☐ Email

AZ Blue 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 If the required information is not received within 30 days, your request will be withdrawn and you will need to resubmit it for consideration.

PERSON AUTHORIZED TO SIGN CONTRACT * e.g., owner, president, CEO, or Board Member	Name and title of the legally valid representative authorized to sign the contract with AZ Blue		
	Contact information:	☐ Phone	☐ Email
GROUP INFORMATION			
NAME *	Legal Name - as on file with the AZ Corporation Commission		Entity ID # (AZ Corp Commission)
	DBA (Doing Business As) Name - if different from above		
NPI *	NPI *(Indicate the NPI used for the primary service location.)*		Effective date (mm/dd/yyyy) / /
TAXONOMY CODE *	Taxonomy Code		Effective date (mm/dd/yyyy) / /
TAX ID *	Tax ID		Date facility started billing with this tax ID # / /
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).		
BUSINESS CONTACT *	Name of contact person for business correspondence		
	Email	Phone	Fax
BUSINESS WEBSITE *	Website		
BUSINESS EMAIL * for contracts and correspondence	Facility Business Email (contracts and correspondence must be sent to the facility, not to a billing company or a consultant)		

Note about addresses: AZ Blue 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

If you have additional locations, please attach a list (be sure to include address, phone, fax, and office hours for each location).

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 AZ Blue 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.

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

MEDICAL RECORDS ADDRESS *
(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. *

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 (AZ Blue) network, or the termination of my existing contract, whichever is applicable.

The Entity consents to complete disclosure of and authorization to make available to AZ Blue, 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 AZ Blue, 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 AZ Blue.

The Entity also authorizes the release of this information to other credentialing entities within or which contract with AZ Blue 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 group or group'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 (mm/dd/yyyy)

Authorized representative of: _____

Group Name

Sign, save, and email this form to Cred@azblue.com.

For more information about contracting with AZ Blue, please visit our **Network Participation page.**

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