



Blue Cross Blue Shield of Arizona (BCBSAZ) Facility and Ancillary Request for Participation Form

IF YOU ARE A PROFESSIONAL GROUP, PLEASE FILL OUT THE PROFESSIONAL INFORMATION FORM.

BCBSAZ and TRICARE credentialing and contracting standards require that BCBSAZ obtain, among other things, required information, such as facility name, physical address and Tax ID#. Confidential information is maintained in contracting and credentialing systems at BCBSAZ for in-house tracking, reporting purposes, and payment of claims.

You have the right to review information submitted by or from other sources in support of your credentialing application, and to correct erroneous information.

ALL REQUIRED FIELDS MUST BE COMPLETED.
The completion of this form does not guarantee network participation.

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

Electronic Provider: (REQUIRED)	Are you an Electronic Provider? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> If you answered No, please call 602-864-4844 or 1-800-656-5656 to set this up.
Facility Name:	Facility Name (Doing Business As): <u>Gila County Office of Health</u> Legal Name (if different than above): <u>Gila County</u> Ownership Structure (i.e., PC, PLLC, LLC, etc.): <u>Government</u> If your organization is a subunit of a larger organization, or if it is owned, operated, managed by, or affiliated with another organization, please indicate the name and address of the organization: _____ _____
Facility or Entity Contact:	Contact Name & Title: <u>Carol Tanner, Senior Administrative Clerk</u> Business Office E-Mail: <u>CTANNER@co.gila.az.us</u> NOTE: Contracts will be sent to Business Email provided. Phone Number: <u>(928) 402-8812</u> Fax Number: <u>(928) 425-0794</u>
Business Website:	Website: <u>WWW.GILACOUNTYAZ.GOV</u> (Optional Information - if provided, it will be displayed in online provider directory)
NPI: (REQUIRED)	Facility NPI: <u>1760547566</u> Eff. date: <u>11 / 01 / 1999</u> Organization NPI (if applicable): <u>486250</u> Eff. date: <u>11 / 01 / 1999</u> Organization Name: <u>Gila County Office of Health - Payson</u>
Tax ID#: (REQUIRED)	Tax ID#: <u>866 000444</u> (to be submitted on claims) Date provider started billing with Tax ID #: <u>11/01/1999</u> (REQUIRED)

License Information:	Facility Open Date: <u>mid 1990's</u> AZ License #: <u>OTC2220</u> Date First Issued: <u>mid 1990's</u> Exp Date: <u>07/31/2013</u> Name as it appears on the License: <u>Gila County Board of Supervisors, dba Gila County Division of Health and Emergency Services - Office of Health, Payson</u> Medicare Certified? Yes/No <u>no</u> Medicare A #: <u>n/a</u> Effective Date: <u>n/a</u> Participate with Medicare? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
Accreditation Information:	Is your facility currently accredited? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> If yes, please indicate by circling the appropriate accrediting organization: (Please attach evidence of current accreditation) AAAHC <input type="checkbox"/> AAAASF <input type="checkbox"/> ADA <input type="checkbox"/> AADE <input type="checkbox"/> AOA (HFAP) <input type="checkbox"/> ACHC <input type="checkbox"/> ACR <input type="checkbox"/> IAC <input type="checkbox"/> AASM <input type="checkbox"/> CABC <input type="checkbox"/> CARF <input type="checkbox"/> CHAP <input type="checkbox"/> KePro <input type="checkbox"/> TJC (JCAHO) <input type="checkbox"/> Other Accreditation (Please Specify): _____
Primary Address: (Main location where services are provided)	Street: <u>107 West Frontier</u> Suite <u>A</u> City: <u>Payson</u> State: <u>AZ</u> Zip Code: <u>85541</u> Phone: <u>928 402 8812</u> Ext: _____ Fax: <u>928 425 0794</u> Days & Hours of Operation: <u>8:00am-5:00pm</u> EACH ADDITIONAL LOCATION WILL REQUIRE A SEPARATE FORM
Credentialing Contact Person and Credentialing Mailing Address (If different from above):	Contact Name: <u>Carol Tanner</u> Title: <u>Sr. Administrative Clerk</u> Street: <u>5515 S. Apache Avenue</u> Suite <u>100</u> City: <u>Globe</u> State: <u>AZ</u> Zip Code: <u>85501</u> Phone: <u>928 402 8812</u> Ext: _____ Fax: <u>928 425 0794</u> E-Mail Address: <u>CTANNER@co.gila.az.us</u>
Mailing Address: (If different than primary location. All correspondence will be sent to this address)	Street: <u>5515 S. Apache Avenue</u> Suite <u>100</u> City: <u>Globe</u> State: <u>AZ</u> Zip Code: <u>85502</u> Phone: <u>928 402 8812</u> Ext: _____ Fax: <u>928 425 0794</u>

Medical Records: (If different than primary location)	Street: <u>SAME AS PRIMARY LOCATION</u> Suite _____ City: _____ State: _____ Zip Code: _____ Phone: _____ Ext: _____ Fax: _____		
Billing Service: (If different than primary address)	Name: <u>Gila County Office of Health</u> Street: <u>5515 S. Apache Avenue</u> Suite <u>100</u> City: <u>Globe</u> State: <u>AZ</u> Zip Code: <u>85501</u> Phone: <u>928 402 8812</u> Ext: _____ Fax: <u>928 425 0794</u>		
Insurance Information:	Please attach a current copy of the facility's Professional Liability [Malpractice] Insurance Certificate with 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 Date: _____		
Primary Specialty: (Check the one most applicable for the facility/entity)	<input type="checkbox"/> Ambulance Company - Air <input type="checkbox"/> Ambulance Company - Ground <input type="checkbox"/> Birthing Center <input type="checkbox"/> Ambulatory Surgery Center (ASC) (includes -Cardiac Cath Lab, >24 Hrs Recovery Care) <input type="checkbox"/> Radiology Center – circle all that apply CT, X-Ray, MRI, PET, Mammography, Ultrasound **ACR Required for CT, MRI, PET** <input type="checkbox"/> Dialysis Center <input type="checkbox"/> Laboratory <input type="checkbox"/> Home Health Agency <input type="checkbox"/> Home Infusion Care (Pharmacy License Req) <input type="checkbox"/> Infusion Center (OP) <input type="checkbox"/> Hospice <input type="checkbox"/> Sleep Lab <input type="checkbox"/> Diabetic Education and Training (ADA Required) <input type="checkbox"/> FQHC (Federally Qualified Health Ctr) - non-hospital	<input type="checkbox"/> <input checked="" type="checkbox"/>	Hospital, Acute Care Hospital, Long Term Acute Care Hospital, Psychiatric Behavioral Health, SubAcute (example: Residential Treatment Center, Rehab Treatment Center) Behavioral Health – OP Programs (example: Partial Hospitalization Program) Skilled Nursing Facility Extended Active Rehabilitation (EAR) Urgent Care Center DME/Medical Supply Orthotics Prosthetics Optical Dispenser Hearing Aid Dispenser Outpatient Treatment Center

**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.

GILA COUNTY


Signature Don E. McDaniel, Jr., County Manager


Date

Michael O'Driscoll
Print Name

Director, Health and Emergency Services
Title

Authorized representative of: Gila County Division of Health and Emergency Services
Institution/Entity

FAX TO: BCBSAZ Network Management (602) 864-3142 Questions: (602) 864-4231

