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: [X] **BCBSAZ Participation** [X] **TRICARE Participation** (copy of W9 required)

Electronic Provider: (REQUIRED)	Are you an Electronic Provider? Yes X No _____ 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): Gila County Office of Health Legal Name (If different than above): Gila County Ownership Structure (i.e., PC, PLLC, LLC, etc.) : Government 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: Carol Tanner, Senior Administrative Clerk Business Office E-Mail: CTANNER@co.gila.az.us **NOTE: Contracts will be sent to Business Email provided.** Phone Number: (928) 402-8812 Fax Number: (928) 425-0794
Business Website:	Website: WWW.GILACOUNTYAZ.GOV **(Optional information – If provided, it will be displayed in online provider directory)**
NPI: : (REQUIRED)	Facility NPI: 1700941507 Eff. date: 11 / 01 / 1999 Organization NPI (if applicable): 479718 Eff. date: 11 / 01 / 1999 Organization Name: Gila County Office of Health
Tax ID#: (REQUIRED)	Tax ID#: 866 000444 (to be submitted on claims) **Date provider started billing with Tax ID #:** 11/01/1999 **(REQUIRED)**

License Information:	Facility Open Date: Mid-1990's AZ License #: OTC3426 Date First Issued: mid 1990's Exp Date: 07/31/2013 Name as it appears on the License: Gila County Board of Supervisors, dba Gila County Division of Health & Emergency Services - Office of Health, Globe Medicare Certified? Yes/No No Medicare A #: n/a Effective Date: n/a Participate with Medicare? Yes X No _____
Accreditation Information:	Is your facility currently accredited? Yes ___ No X If yes, please indicate by circling the appropriate accrediting organization: **(Please attach evidence of current accreditation)** AAAHC_____ AAAASF_____ ADA_____ AADE_____ AOA (HFAP) _____ ACHC_____ ACR____ IAC_____ AASM_____ CABC_____ CARF _____ CHAP_____ KePro _____ TJC (JCAHO)_____ Other Accreditation (Please Specify): _____
Primary Address: (Main location where services are provided)	Street: 5515 S. Apache Avenue Suite 100 City: Globe State: AZ Zip Code: 85501 Phone: 928-402-881 Ext: _____ Fax: 928-425-0794 Days & Hours of Operation: M-F 8:00am-5:00pm **EACH ADDITIONAL LOCATION WILL REQUIRE A SEPARATE FORM**
Credentialing Contact Person and Credentialing Mailing Address **(if different from above):**	Contact Name Carol Tanner Title: Sr. Administrative Clerk Street: 5515 S. Apache Avenue Suite 100 City: Globe State: AZ Zip Code: 85501 Phone: 928-402-8812 Ext: _____ Fax: 928-425-0794 E-Mail Address: CTANNER@co.gila.az.us
Mailing Address: (If different than primary location. All correspondence will be sent to this address)	Street: 5515 S. Apache Avenue Suite 100 City: Globe State: AZ Zip Code: 85501 Phone: 928-402-8812 Ext: _____ Fax: 928-425-0794

Medical Records: (If different than primary location)	Street: SAME AS PRIMARY LOCATION Suite _____ City: _____ State: _____ Zip Code: _____ Phone: _____ Ext: _____ Fax: _____
Billing Service: (If different than primary address)	Name: Same as Primary Location Street: _____ Suite _____ City: _____ State: _____ Zip Code: _____ Phone: _____ Ext: _____ Fax: _____
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)

	Ambulance Company - Air		Hospital, Acute Care
	Ambulance Company - Ground		Hospital, Long Term Acute Care
	Birthing Center		Hospital, Psychiatric
	Ambulatory Surgery Center (ASC) (includes -Cardiac Cath Lab, >24 Hrs Recovery Care)		Behavioral Health, SubAcute (example: Residential Treatment Center, Rehab Treatment Center)
	Radiology Center – **circle all that apply** CT, X-Ray, MRI, PET, Mammography, Ultrasound **ACR Required for CT, MRI, PET**		Behavioral Health – OP Programs (example: Partial Hospitalization Program)
	Dialysis Center		Skilled Nursing Facility
	Laboratory		Extended Active Rehabilitation (EAR)
	Home Health Agency		Urgent Care Center
	Home Infusion Care (Pharmacy License Req)		DME/Medical Supply
	Infusion Center (OP)		Orthotics
	Hospice		Prosthetics
	Sleep Lab		Optical Dispenser
	Diabetic Education and Training (ADA Required)		Hearing Aid Dispenser
	FQHC (Federally Qualified Health Ctr) - non-hospital	X	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 8/28/12

Michael O'Driscoll — Print Name

Director, Health & 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

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY) 08/20/2012

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER 1-800-955-8700 Arthur J. Gallagher & Co. Insurance Brokers of California, Inc. 15 Enterprise, Ste 200 Aliso Viejo, CA 92656	CONTACT NAME: PHONE (A/C, No, Ext): 480-845-6209 FAX (A/C, No): 602-244-2242 E-MAIL ADDRESS: rose_unruh@ajg.com
INSURED Gila County Attn: Birdie DeNero 1400 E. Ash Street Globe, AZ 85501	INSURER(S) AFFORDING COVERAGE — NAIC # INSURER A: Arizona Counties Insurance Pool INSURER B: Arizona Counties Workers Comp Pool INSURER C: INSURER D: INSURER E: INSURER F:

COVERAGES **CERTIFICATE NUMBER:** 28744683 **REVISION NUMBER:**

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSR	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
A	GENERAL LIABILITY X COMMERCIAL GENERAL LIABILITY CLAIMS-MADE X OCCUR X Public Officials' E&O X Misc Medical Mal E&O GEN'L AGGREGATE LIMIT APPLIES PER: X POLICY PRO-JECT LOC			ACIP070112	07/01/12	07/01/13	EACH OCCURRENCE DAMAGE TO RENTED PREMISES (Ea occurrence) MED EXP (Any one person) PERSONAL & ADV INJURY GENERAL AGGREGATE PRODUCTS - COMP/OP AGG Errors & Omissions	$ 1,000,000 $ $ $ $ 4,000,000 $ $ 1,000,000
A	AUTOMOBILE LIABILITY X ANY AUTO ALL OWNED AUTOS SCHEDULED AUTOS X HIRED AUTOS X NON-OWNED AUTOS			ACIP070112	07/01/12	07/01/13	COMBINED SINGLE LIMIT (Ea accident) BODILY INJURY (Per person) BODILY INJURY (Per accident) PROPERTY DAMAGE (Per accident) Comp Ded/Coll Ded:	$ 1,000,000 $ $ $ $ 1,500/$1,500
	UMBRELLA LIAB OCCUR EXCESS LIAB CLAIMS-MADE DED RETENTION $						EACH OCCURRENCE AGGREGATE 	$ $ $
B	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) Y/N: N If yes, describe under DESCRIPTION OF OPERATIONS below	N/A		CRLAZWC070112	07/01/12	07/01/13	X WC STATU-TORY LIMITS OTH-ER E.L. EACH ACCIDENT E.L. DISEASE - EA EMPLOYEE E.L. DISEASE - POLICY LIMIT	 $ 1,000,000 $ 1,000,000 $ 1,000,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (Attach ACORD 101, Additional Remarks Schedule, if more space is required)

Proof of coverage for Gila County Health & Emergency Services Department for all of County's outpatient treatment center locations.

CERTIFICATE HOLDER

Blue Cross Blue Shield

2480 W. Las Palmaritas Drive

Phoenix, AZ 85021 USA

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE