Blue Shield Provider Application

Dear Prospective Providers: Please complete this form and return it to the address below. Incomplete or illegible forms will be returned.

PART 1: TAX AND BILLING INFORMATION

Tax Identification Number (EIN)		or Social Security Number	
Business Name as filed with the IRS			
Doing Business As (DBA), if applicable			

MAILING ADDRESS FOR PAYMENTS

Street Address		Suite/Room/Unit	City	State	Zip	County

Billing Contact: Name		Contact Phone #	

PART 2: NPI INFORMATION

Type 2 NPI # (corporation/group)		Type 1 NPI # (individual practice)	

PART 3: PRACTICE INFORMATION

Name (If this name is different than how you have filed with the IRS, it will be listed as a DBA on our files)			
Primary Specialty Practice		Subspecialty	

OFFICE INFORMATION* ***(PO Boxes are not acceptable as an Office Address)***

Primary Site

Office Street Address (Place of Service to members)		Suite/Room/Unit	City	State	Zip	County

Phone	( )	Fax	( )	Email	

Hours of Operation	☐ Sun	☐ Mon	☐ Tue	☐ Wed	☐ Thu	☐ Fri	☐ Sat

Secondary Site

Office Street Address (Place of Service to members)		Suite/Room/Unit	City	State	Zip	County

Phone	( )	Fax	( )	Email	

Hours of Operation	☐ Sun	☐ Mon	☐ Tue	☐ Wed	☐ Thu	☐ Fri	☐ Sat

If more than one site and more than one staff member, please indicate which location(s) the physician or provider will be practicing.

For each physician or provider, complete Part 4.

For questions regarding information provided on this form, please contact:

Name		Title		Phone	( )

I do affirm that all of the above information is true.

Authorized Name		Authorized Signature	
Signature Date			

Return completed form to:

Blue Cross and Blue Shield of Illinois
300 E. Randolph | Chicago, Illinois 60601
Network Operations – 23rd Floor
Fax: 312-540-8609

*additional locations linked to this registration should be listed on office letterhead and attached

PART 4: REQUIRED FOR EACH PROVIDER
(Complete where applicable by specialties for providers within your group or individual practice.)

PROVIDER FULL NAME							
First Name		Middle Initial		Last Name		Medical Initials	
CAQH#							
Professional License Number				State of Issue			
Professional License Number				State of Issue			
Social Security Number	(Needed for Setup for access BCBS Secure Provider Portal)						
Type 1 NPI (Individual)				Gender	☐ Male ☐ Female		
Practice Specialty at this Location				Are you board certified for this specialty? ☐ Yes ☐ No			
Practice Specialty Two				Are you board certified for this specialty? ☐ Yes ☐ No			
Practice Specialty Three				Are you board certified for this specialty? ☐ Yes ☐ No			
Are you accepting new patients?	☐ Yes ☐ No						
Primary Hospital Affiliation Name, City, State (if applicable)				City		State	
Other Hospital Affiliations							
Medical School				Year of Graduation			
Internship (Institution Name and Location)				Month-Year			
Residency (Institution Name and Location)				Month-Year			
Fellowship (Institution Name and Location)				Month-Year			
Languages (Spoken or Written)							

- ☐ I do not have hospital privileges
- ☐ Refer patients to Primary Care Physician
- ☐ Refer patients via the emergency room
- ☐ Hospital affiliation not required for practicing specialty
- ☐ Use a covering Physician/Hospitalist

Name		License Number		Tax Identification Number (EIN)	