BlueCross BlueShield of Illinois

Print Form

PROVIDER PRE-APPLICATION

Please provide the site name and number for each product provider is applying for:

Name:

HMO Illinois | Blue Advantage | Blue Precision | Blue Focused Care | Medicare Advantage

Government Contract Name: | Group NPI

Medicare/Medicaid Alignment | MMAI Tax ID #: | Medicaid | Medicaid Tax ID#:

Contracting Name: | Group NPI

☐ Blue Choice PPO ☐ PPO ☐ PPO Medicare Advantage ☐ Family Health Plan (FHP) | Tax ID #:

APPLICATION FOR (Please check)

Required for Government Programs

Does provider treat the following?

	Yes	No		Yes	No
Homeless			Serious Mental Illness		
Blind or Visually Impaired			Co-Occurring Disorders		
Chronic Illiness			Physical Disabilities		
HIV/AIDS			Deafness or Hard of Hearing		
Homebound members					

☐ PCP (Primary Care Physician) ☐ Hospitalist

☐ Internal Medicine ☐ Pediatrics ☐ Family Practice ☐ OBG ☐ CNM

☐ PSP (Participating Specialist Physician) ☐ Dual Specialty (Both PCP and PSP)

Practicing Specialty:

PROVIDER INFORMATION

Last Name | First Name | MI | Degree

Gender: ☐ Male ☐ Female | Date of Birth | Email

Does the provider have a CAQH Provider ID? ☐ Yes ☐ No | If yes, please indicate the number:

LICENSE AND CERTIFICATIONS

National Provider Identification Number (NPI)

Illinois Professional License Number:

License Unlimited ☐ Yes ☐ No

*Supervising Physician Name

(required if IL License Prefix is 209 for APN and 085 for PA)

License Number

(of Supervising Physician)

Current Federal DEA License Number:

Medicaid ID Number:

Medicare ID Number:

Does the provider have admitting privileges? ☐ Yes ☐ No

If yes, please indicate which hospital(s)

What is the provider's current Malpractice limit? Per Occurrence Aggregate

Primary Specialty:

Board Certified? ☐ Yes ☐ No

If no, is the provider planning to become board certified? ☐ Yes ☐ No

Practicing Specialty I:

Board Certified? ☐ Yes ☐ No

If no, is the provider planning to become board certified? ☐ Yes ☐ No

Practicing Specialty II:

Board Certified? ☐ Yes ☐ No

If no, is the provider planning to become board certified? ☐ Yes ☐ No

Primary Location

Group Name:

Office Address - Number and Street - Suite

City State County Zip

Phone Number Fax Number

Practicing Specialty at Location:

Accepting new patients? ☐ Yes ☐ No

In close proximity to transportation? ☐ Yes ☐ No Does your office have a Language Line Interpreter? ☐ Yes ☐ No

Are the following handicap accessible in accordance with Americans with Disability Act (ADA) standards?
(Note: Required to be filled out for Government Business)

	Yes	No		Yes	No		Yes	No
Site ADA Accessible			Interior Building			Office Reception Area		
Parking Accessibility			Exam Room			Restroom		
Exterior Building			Exam table			Scale		

Reference: http://www.ada.gov/

*Supervising physician must be in the same network

Office Hours

Days of Week	Morning	Afternoon	Evening	
Sunday				How many Sundays a month?
Monday				
Tuesday				
Wednesday				
Thursday				
Friday				
Saturday				How many Saturdays a month?

Second Location

Group Name:

Office Address - Number and Street - Suite

City State County Zip

Phone Number Fax Number

Practicing Specialty at Location: Accepting new patients? ☐ Yes ☐ No

In close proximity to transportation? ☐ Yes ☐ No Does your office have a Language Line Interpreter? ☐ Yes ☐ No

Are the following handicap accessible in accordance with Americans with Disability Act (ADA) standards?
(Note: Required to be filled out for Government Business)

	Yes	No		Yes	No		Yes	No
Site ADA Accessible			Interior Building			Office Reception Area		
Parking Accessibility			Exam Room			Restroom		
Exterior Building			Exam table			Scale		

Office Hours

Days of Week	Morning	Afternoon	Evening	
Sunday				How many Sundays a month?
Monday				
Tuesday				
Wednesday				
Thursday				
Friday				
Saturday				How many Saturdays a month?

Third Location

Group Name:

Office Address - Number and Street - Suite

City State County Zip

Phone Number Fax Number

Practicing Specialty at Location: Accepting new patients? ☐ Yes ☐ No

In close proximity to transportation? ☐ Yes ☐ No Does your office have a Language Line Interpreter? ☐ Yes ☐ No

Are the following handicap accessible in accordance with Americans with Disability Act (ADA) standards?
(Note: Required to be filled out for Government Business)

	Yes	No		Yes	No		Yes	No
Site ADA Accessible			Interior Building			Office Reception Area		
Parking Accessibility			Exam Room			Restroom		
Exterior Building			Exam table			Scale		

Office Hours

Days of Week	Morning	Afternoon	Evening	
Sunday				How many Sundays a month?
Monday				
Tuesday				
Wednesday				
Thursday				
Friday				
Saturday				How many Saturdays a month?

CONTACT INFORMATION

Please provide your contact information for questions related to the completion of this application.

Contact Name:		Telephone:	
Contact E-mail		Fax Number:	

Please submit completed forms to:
HMO Department
HMO_Network@BCBSIL.com
or fax to (312)946-3714