Out-of-Network Provider Request

After completing the form, please email to: PNS_GM@bcbst.com or fax to (423) 535-5808

IMPORTANT: Submission of this form is not a request to participate in any BlueCross BlueShield of Tennessee provider network. If you would like to apply as a network provider, please complete an enrollment form at: bcbst.com/providers. (Office must be in Tennessee or a county contiguous to Tennessee.) You must submit a copy of your current medical license(s) and IRS Form 147c with this form.

Provider Name: _____ NPI: _____
(First name or Organizational Name, Middle Initial, Last Name, Generation and Degree)

Specialty/Taxonomy Requested: _____ Tax Identification Number: _____

Medical License State 1 (REQUIRED): State: _____ License Number: _____

Medical License State 2: State: _____ License Number: _____

Social Security Number (REQUIRED FOR INDIVIDUALS): _____

Medicare Number: _____ DEA Number: _____

Demographic Information:

Physical Practice Location (No P.O. Boxes, please)

_____

_____

_____

Mailing /Correspondence Address:

Mail, other than checks, will be sent to this address

☐ Same as physical practice location address (above)

☐ Same as pay-to address (listed to the right)

☐ Other _____

_____

_____

Office Hours: _____

Office Telephone Number: _____

Office Fax Number: _____

Payments:

Make checks payable to:

_____

☐ Roll payments up to single check for all providers in the Group?

☐ Payments should be made for individual provider?

Pay-To Address: _____

_____

_____

IRS (W-9) Name: _____

IRS (W-9) Address: _____

_____

_____

Group Name, if applicable:

_____

Group NPI: _____
(Required for group payments)

If you want to file claims electronically for this location, please complete an Ecomm profile form at: www.bcbst.com/providers/ecomm/getting_started/profile_provider.pdf.

If you want to receive payment by electronic funds transfer, please visit: https://solutions.caqh.org/.

Completed by: _____ Date: _____

Please provide the name and information for the contact person if we have questions about this form:

Name: _____

Phone: _____ Email: _____

If you have any questions regarding completion of this form, please contact Provider Network Services at 1-800-924-7141.