



Regence

Regence BlueCross BlueShield of Oregon is an Independent Licensee of the Blue Cross and Blue Shield Association

Hospital and Free-Standing Facility Based Practitioner Information Form

I - INSTRUCTIONS

This form should be typed or legibly printed in black ink. Applicable to those practitioners who practice within the inpatient setting, hospital setting or free-standing facility setting.

Hospital and Free-Standing Facility Based Practitioners are defined as:

Practitioners who practice exclusively within the inpatient setting, hospital setting, or free-standing facility based setting and who provide care for Regence BlueCross BlueShield of Oregon members only as a result of members being directed to the inpatient setting, hospital setting or free-standing facility. Examples of free-standing facilities are, but are not limited to, surgery centers, nursing homes and radiology centers.

Current copies of the following documents must be submitted with this form as applicable:

- ◆ State Professional License(s)
- ◆ DEA Certificate
- ◆ Proof of Insurance
- ◆ W-9

Send a completed form with attachments to: **OR** Fax the completed form with attachments to:

**Regence BlueCross BlueShield of Oregon
Provider Enrollment and Maintenance
PO Box 1271 M/S E7H
Portland, OR 97201-1271**

**Regence BlueCross BlueShield of Oregon
Provider Enrollment and Maintenance
(503) 225-5174**

If you have any questions, contact Regence BlueCross BlueShield of Oregon Provider Services at 1 (800) 722-5086.

II - HOSPITAL AND FREE-STANDING FACILITY BASED PRACTITIONER INFORMATION

Last Name (include suffix; Jr., Sr., III)		First Name		Middle Initial	Degree(s)
Hospital Name and Address					
Street Address where services will be provided			City, State, ZIP Code		
Billing Address (if different than above)			Effective Date	Tax Identification Number	
Telephone Number		Fax Number	Billing Telephone Number		Date of Birth
<input type="checkbox"/> Male <input type="checkbox"/> Female	NPI Number		Citizenship		
Professional License Number			State	Issue Date	Expiration Date
Drug Enforcement Administration (DEA) Registration Number					Expiration Date
NPI: If you are a Type 2 provider as defined by CMS, please contact your provider relations representative to report your NPI to Regence.					
Specialty/Sub Specialties			Are you board certified? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, please provide the name of the board, specialty and date certified.		
MD/DO's only: Medical School Attended				Year graduated from medical school	
Do you practice at any other location(s)? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, list the address and Tax Identification Number (Attach a separate page for all practice locations)			Accept Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have an existing Individual or Clinic contract with Regence (please check one): <input type="checkbox"/> Individual <input type="checkbox"/> Clinic	
Social Security Number			Practitioner or Administrator Signature		

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