Request for Application (Organization)

To	Date Request Submitted
From	**Region**

- ☐ Ambulatory Surgery Center
- ☐ Ambulance – Air
- ☐ Ambulance-Ground
- ☐ Birthing Center
- ☐ CORF
- ☐ Community Mental Health Center
- ☐ Dialysis Center
- ☐ Diabetic Education Program
- ☐ Durable Medical Equipment
- ☐ Family Planning
- ☐ FQHC
- ☐ Hospital, Acute Care
- ☐ Hospital, Critical Access
- ☐ Hospital, Psychiatric
- ☐ Hospital, Rehabilitation
- ☐ Hospital, Rural Emergency
- ☐ Home Health Agency
- ☐ Home Infusion Therapy
- ☐ Hospice
- ☐ Independent Lab
- ☐ Imaging Center
- ☐ Long Term Acute Care
- ☐ Mass Immunization
- ☐ Out of State Org (BCBSA Required to file claims)
- ☐ Pharmacy
- ☐ Physical Therapy Center
- ☐ Portable X-Ray
- ☐ Radiation Therapy Center
- ☐ Optician
- ☐ Orthotics/Prosthetics
- ☐ Residential Treatment Center
  - ☐ Substance Abuse
  - ☐ Behavioral Health
  - ☐ Inpatient Detox
- ☐ Rural Health Center
- ☐ Skilled Nursing Facility
- ☐ Sleep Study Lab
- ☐ Specialty Pharmacy
- ☐ Urgent Care Center

☐ Clinic/Group* - *If you are a NEW clinic or group practice, with providers that need to be attached, please have the provider(s) fill out and upload the clinic authorization form located in the Hub.

Organization name		**NPI number**
Address of organization (PO Boxes are Not Acceptable)		**Date opened**
City	**State**	**ZIP**
License number	**State**	**CMS number**
Accreditation		
PHO/Group (if will be added to PHO/group contract)		
Administrators name		**Administrators phone**
Administrators email address		

Networks requested

☐ Preferred Payment Plan ☐ True Blue PPO ☐ Health Advantage HMO ☐ Arkansas Blue Medicare
☐ Arkansas FirstSouce ☐ Non participating

Send completed applications to the Network Development Representative for your region. Contact information can be found here: www.skaibcbs.com/ndrs