

## Provider Information

Provider Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Email Address: \_\_\_\_\_

Individual NPI: \_\_\_\_\_ SSN: \_\_\_\_\_ DOB: \_\_\_\_\_

NE Lic Number: \_\_\_\_\_ Provisional Supervisor: \_\_\_\_\_

Requested Effective Date - Needs to be a future date or the receive date will be given: \_\_\_\_\_

## Physical and Billing Address

Tax ID for Claim Filing: \_\_\_\_\_ Office Name: \_\_\_\_\_

Office Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Office Phone: \_\_\_\_\_ Office Fax: \_\_\_\_\_

Payment Name: \_\_\_\_\_

Billing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Billing Phone: \_\_\_\_\_ Billing Fax: \_\_\_\_\_

## Education History

School(s) Attended	Dates	Degree and Year Graduated

## Specialty Information

Specialty: \_\_\_\_\_

Sub-Specialty: \_\_\_\_\_

Professional Membership / Appointments:

Academic Appointments, Research, Publications:

Provider Name: \_\_\_\_\_ SSN: \_\_\_\_\_

### Professional Experience - Past Five Years

Organization Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Start Date: \_\_\_\_\_ End Date: \_\_\_\_\_ Position Held: \_\_\_\_\_

Organization Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Start Date: \_\_\_\_\_ End Date: \_\_\_\_\_ Position Held: \_\_\_\_\_

### Liability Insurance

Insurance Provider: \_\_\_\_\_

Provider's Address: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Policy Limit(s): \_\_\_\_\_

Have there been any gaps in liability coverage in the past five years?  Yes  No

Do you have previous or pending judgments or settlements in liability cases?  Yes  No

Have you ever been convicted of, or plead guilty to, a felony?  Yes  No

If you answered "yes" to any of the above, please explain (include dates, reasons, results, etc.):

### Attestation and Authorization

I certify that the above information is accurate and true, and I authorize any third party to release any information concerning this application to Blue Cross and Blue Shield of Nebraska.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Supervisor Signature: \_\_\_\_\_ Date: \_\_\_\_\_