CareFirst
Family of health care plans

Ambulance Application Questionnaire

Complete this form to be considered for participation in our provider network(s).

Please attach the following: **W-9, License, Malpractice Insurance**

General Information

Group Name	
Service Specialty: Ambulance Service	Provider Type: Ambulance
Tax Identification	Billing NPI (Type 2)

Authorized Office Manager/Contact Person

First Name	Job Title
Phone Number Extn	Last Name
	Email Address

Licenses

License Name	State	Date of Issuance

Insurance

Insurance Name	Policy Number	Coverage Type: Aggregate

Occurrence Amt	Aggregate Amt	Effective Date	Expiration Date

Tax Address (to receive 1099 form)

Street Address		Telephone Number	
City	State	County	Zip Code

Mailing Address (to receive claim forms, publications and other correspondence)

Street Address		Telephone Number	
City	State	County	Zip Code
Email Address			

Payment Address, if different from above (to receive reimbursement checks)

Street Address		Office Telephone Number	
City	State	County	Zip Code

Primary Service Location

Street Address		Location Telephone Number	Effective Date
City	State	County	Zip Code

Additional Service Locations

Service Location		Effective Date	
Street Address		Location Telephone Number	
City	State	County	Zip Code

Service Location		Effective Date	
Street Address		Location Telephone Number	
City	State	County	Zip Code

Service Location		Effective Date	
Street Address		Location Telephone Number	
City	State	County	Zip Code

Service Location		Effective Date	
Street Address		Location Telephone Number	
City	State	County	Zip Code

Service Location		Effective Date	
Street Address		Location Telephone Number	
City	State	County	Zip Code

Request for Information (RFI) Application

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INSTRUCTIONS

Designed for ancillary and hospital providers to apply for participation in the CareFirst BlueCross BlueShield and/or CareFirst BlueChoice, Inc. (CareFirst) networks for services rendered in the CareFirst service area of Maryland, Washington, D.C, and Northern Virginia.

- Type or print all sections of this form. Responses may be supported by attachments. If a question or entire section does not apply to your organization, **indicate N/A**.
- Failure to complete all sections, or indicate N/A when the requested information does not apply, may delay processing.
- Email addresses must be provided as electronic communication is required for parts of the CareFirst service area.

Submit form to: CareFirst BlueCross BlueShield and CareFirst BlueChoice, Inc., Institutional Contracting, Mailstop CG-51, 10455 Mill Run Circle, Owings Mills, MD 21117, Phone: 410-872-3526, Fax: 410-505-2765.

PROVIDER INFORMATION

Legal Name of Provider (as registered with IRS and listed on IRS Form W-9 Request for Taxpayer Identification Number and Certification. Please include dba, if applicable.)

Do you currently participate with CareFirst under another provider name?
◯ Yes ◉ No
If yes, please indicate the provider name and tax identification number.

Would you like the legal name printed above to appear as listed in our participating provider directories?
◯ Yes ◉ No
If no, please print provider name as you want it to appear in our participating provider directories and attach corresponding W-9 form.

Is the Organization Incorporated? ◯ Yes ◯ No If yes, list below status of incorporation.	Effective Date of Corporation

AGREEMENT CONTACT INFORMATION

Who will be signing the Agreements?

Name	Title

Agreement Mailing Address (P.O. Box is not acceptable)

Street	City	State	Zip (plus four)

Email Address to Send Agreements for Signature

LEGAL NOTICES INFORMATION

Who will receive any legal notices?

Name	Title

Legal Notices Mailing Address (P.O. Box is not acceptable)

Street	City	State	Zip (plus four)

Phone	Email Address of Contact for Contract Updates or Notifications