



# Regence

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

## Hospital Based Practitioner Information Form

### I - INSTRUCTIONS

This form should be typed or legibly printed in black ink. Applicable to those practitioners who are employed by the hospital or practicing solely as a hospital based practitioner.

**Hospital Based Practitioners are defined as:**

Practitioners who practice exclusively within the inpatient setting and who provide care for Regence BlueCross BlueShield of Utah members only as a result of members being directed to the hospital or other inpatient setting.

**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 Utah  
Provider Enrollment and Maintenance  
PO Box 30270 M/S 26  
Salt Lake City, UT 84130-0270**

**Regence BlueCross BlueShield of Utah  
Provider Enrollment and Maintenance  
1 (801) 333-6558**

If you have any questions, contact Regence BlueCross BlueShield of Utah Provider Services at 1 (801) 333-2600.

### II - HOSPITAL 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		
<b>NPI: If you are a Type 2 provider as defined by CMS, please contact your provider relations representative to report your NPI to Regence.</b>					
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.		
<b>MD/DO's only:</b> 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				Do you have an existing <b>Individual</b> or <b>Clinic</b> 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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