New clinic/group application

Type of clinic services
☐ Primary Care ☐ Specialty Care ☐ Urgent Care ☐ Billing/Hospitalist/Emergency Service group ONLY

Name of clinic/group	**Signage name displayed to patients** (if different)
Does anyone at this location provide sign language? ☐ Yes ☐ No	**Do you provide TTY services?** ☐ Yes ☐ No

Effective date	**Clinic/Group EIN**	**Clinic/Group NPI number**

Location

Street address of clinic/group		**County**
City	**State**	**ZIP**

Phone for patient appointments	**Clinic/Group fax**	**Contact person**
Contact phone	**Clinic/Group email**	

Web URL

Office hours at this location ☐ Full time ☐ Part time

	Monday	**Tuesday**	**Wednesday**	**Thursday**	**Friday**	**Saturday**	**Sunday**
Open							
Close							

Correspondence

Correspondence address of clinic/group (if different than above location)		**County**
City	**State**	**ZIP**

Correspondence phone	**Clinic/Group fax**
Contact person	**Contact phone**

Payment

Payment address of clinic/group (if different than above location)		**County**
City	**State**	**ZIP**

Payment phone	**Clinic/Group fax**
Contact person	**Contact phone**

Additional locations

Location name

Address	City	State	ZIP

Phone for patient appointments	Clinic/Group fax

Office hours at this location ☐ Full time ☐ Part time

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Open							
Close							

Location name

Address	City	State	ZIP

Phone for patient appointments	Clinic/Group fax

Office hours at this location ☐ Full time ☐ Part time

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Open							
Close							

Location name

Address	City	State	ZIP

Phone for patient appointments	Clinic/Group fax

Office hours at this location ☐ Full time ☐ Part time

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Open							
Close							

Signature

Print name and title of authorized facility representative	Title
Signature	**Date of signature**

Return completed form to and supporting documents:

Arkansas Blue Cross and Blue Shield
ATTN: Provider Network Operations
PO Box 2181
Little Rock AR 72203-2181

or

Fax: 501-378-2465
Email: providernetwork@arkbluecross.com

Arkansas BlueCross BlueShield
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Health Advantage
An Independent Licensee of the Blue Cross and Blue Shield Association