



# VERIFICATION OF HOSPITAL PRIVILEGES

**Practitioner to fill in top portion and then forward to primary hospital for completion of verification.**

*I hereby grant permission and consent to the release by any person, organization, or other entity to BCBSI and/or its designee, of all information that may be reasonably relevant to an evaluation of my professional competence, ability to render clinical services in a cost-effective manner, character and moral and ethical qualifications and agree to hold harmless any such person or organization or other entity from any cause of action based on the release of such information to BCBSI and /or designee. I understand that participation as provider for the program is dependent upon review of this application and completion of the credentialing process.*

Practitioner Signature

State License Number

Print Name

Specialty

Name of Group (if any)

[Information below must be completed by the hospital.](#)

1.) MEMBERSHIP STATUS: \_\_\_\_\_

2.) DATE OF APPOINTMENT: \_\_\_\_\_

3.) CLINICAL PRIVILEGES IN GOOD STANDING? YES  NO

4.) DOES THIS PROVIDER HAVE ADMITTING PRIVILEGES? YES  NO

5.) ANY LIMITATIONS OR RESTRICTIONS AT THIS HOSPITAL: \_\_\_\_\_

Signature of Chief of Medical Staff or Designee

Position

Hospital Name

Date

**Return via fax to (312) 938-3178 or to**

BlueCross BlueShield of Illinois  
Corporate Credentialing, 23<sup>rd</sup> Floor  
300 East Randolph Street  
Chicago, Illinois 60601-5099

Phone (312) 653-2775