BlueCross BlueShield of Illinois

Independent Lab Questionnaire

for Participating Status with Blue Cross and Blue Shield of Illinois

Please complete and upload this questionnaire and credentials below with your Provider Onboarding submission. After review and approval of your application and credentials, BCBSIL will assess your eligibility for a contract.

- Certificate of Insurance
- Accreditation Certificate
- Medicare Certification
- NPI Enumerator Response
- W-9 Form

NAME OF INDEPENDENT LAB				
ADDRESS	CITY	STATE	ZIP	COUNTY
E-MAIL ADDRESS	PHONE (INC. AREA CODE)		FAX (INC. AREA CODE)	
PAYEE NAME	CONTRACTING ENTITY (IF APPLICABLE)			
ADDRESS	CITY	STATE	ZIP	COUNTY

MULTIPLE LOCATION(S) CITY? ☐ YES ☐ NO
IF **YES**, THIS REQUIRES AN APPLICATION AND CREDENTIALS FOR EACH LOCATION

IS THE INDEPENDENT LAB CERTIFIED BY MEDICARE? ☐ YES ☐ NO	MEDICARE PROVIDER NUMBER	DATE OF CERTIFICATION (MM/DD/YYYY)
MEDICAID #	**NATIONAL PROVIDER IDENTIFIER NUMBER**	**FEDERAL TAX IDENTIFICATION NUMBER**
IS THE INDEPENDENT LAB ACCREDITED BY CLIA, COLA OR THE JOINT COMMISSION ACCREDITATION OR SIMILAR ACCREDITING BODY? ☐ YES ☐ NO	IF YES, EXPIRATION DATE OF ACCREDITATION (MM/DD/YYYY)	ACCREDITATION NAME
CERTIFICATE OF INSURANCE BY	EFFECTIVE DATE (MM/DD/YYYY)	EXPIRATION DATE (MM/DD/YYYY)

ATTACH A COPY OF CURRENT INSURANCE BINDER WITH EXPIRATION DATE

DOES THE PROVIDER HAVE ANY FUNCTIONS, ACTIVITIES OR SERVICES BEING USED OFF-SHORE?
☐ YES ☐ NO

PLEASE INDICATE YOUR EXPERIENCE IN TREATING THE FOLLOWING CATEGORIES:

☐ HOMELESS	☐ CHRONIC ILLNESS	☐ SERIOUS MENTAL ILLNESS
☐ HIV/AIDS	☐ DEAFNESS OR HARD-OF-HEARING	☐ BLINDNESS OR VISUAL IMPAIRMENT
☐ PHYSICAL DISABILITIES		☐ CO-OCCURRING DISORDERS

ARE THE FOLLOWING STANDARDS IN ACCORDANCE WITH AMERICANS WITH DISABILITIES ACT? (NOTE: REQUIRED TO BE FILLED OUT FOR GOVERNMENT BUSINESS)

SITE ACCESSIBLE ☐ YES ☐ NO	INTERIOR BUILDING ☐ YES ☐ NO	OFFICE RECEPTION AREA ☐ YES ☐ NO
PARKING ACCESSIBILITY ☐ YES ☐ NO	EXAM ROOM ☐ YES ☐ NO	RESTROOM ☐ YES ☐ NO
EXTERIOR BUILDING ☐ YES ☐ NO	EXAM TABLE ☐ YES ☐ NO	SCALE ☐ YES ☐ NO
CLOSE PROXIMITY TO PUBLIC TRANSPORTATION ☐ YES ☐ NO		

HOURS OF OPERATION	SUN	MON	TUE	WED	THU	FRI	SAT
	______ AM – ______ PM	______ AM – ______ PM	______ AM – ______ PM	______ AM – ______ PM	______ AM – ______ PM	______ AM – ______ PM	______ AM – ______ PM

LANGUAGES SPOKEN ON SITE AND/OR OFF SITE	LANGUAGE LINE INTERPRETER ☐ YES ☐ NO

QUESTIONNAIRE PREPARED BY:

NAME	TITLE		
ADDRESS	CITY	STATE	ZIP
EMAIL			
SIGNATURE		DATE (MM/DD/YYYY)	