blue california

PROVIDER APPLICATION REQUEST FORM

(For CAQH participants only)

CAQH Number:			
Medical License/Certification Number:			
NPI Number:			
Date of Birth:			
Provider Last and First Name:			
Requested Contract Entity:	☐ Blue Shield of California Health Plan ☐ Blue Shield of California Promise Health Plan		
Contract Status:	Medical Group Name: ☐ Contract Established/Existing ☐ Contract Pending		
Requested Contract Primary Specialty:		**Requested Contract Secondary Specialty:**	
Requested Line of Business:	☐ Medicare Medicare #:	☐ TriWest	☐ Medi-Cal MediCal #:
	☐ Cal MediConnect	☐ Others	
Credentialing Mailing Address:			
Credentialing Contact Name:			
Credentialing Contact Email:			
Credentialing Contact Phone:			
Physical Location(s) (as it will appear on directory. If it is the same as above, type "Same as Above"):			

Please email the completed form to BSCInitialApp@blueshieldca.com.