

# Request for Application (Organization)

To	Date Request Submitted
From	Region
Ambulatory Surgery Center	Hospital, Rehabilitation
Ambulance – Air	Hospital, Rural Emergency
Ambulance-Ground	Home Health Agency
Birthing Center	Home Infusion Therapy
CORF	Hospice
Community Mental Health Center	Independent Lab
Dialysis Center	Imaging Center
Diabetic Education Program	Long Term Acute Care
Durable Medical Equipment	Mass Immunization
Family Planning	Out of State Org (BCBSA)
FQHC	Required to file claims)
Hospital, Acute Care	Pharmacy
Hospital, Critical Access	Physical Therapy Center
Hospital, Psychiatric	Portable X-Ray

**Clinic/Group\*** - \*If you are a NEW clinic or group practice, with providers that need to be attached, please have the provider(s) fill out and upload the clinic authorization form located in the Hub.

Organization name	NPI number	
Address of organization (PO Boxes are Not Acceptable)		Date opened
City	State	ZIP
License number	State	CMS number

## Accreditation

**PHO/Group** (if will be added to PHO/group contract)

Administrators name	Administrators phone
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Administrators email address

## Networks requested

Preferred Payment Plan      True Blue PPO      Health Advantage HMO      Arkansas Blue Medicare  
 Arkansas FirstSouce      Non participating

**Send completed applications** to the Network Development Representative for your region. Contact information can be found here: [arkansasbluecross.com/providers/resource-center/network-development-reps](http://arkansasbluecross.com/providers/resource-center/network-development-reps)