Blue Cross Blue Shield of Rhode Island
500 Exchange Street, Providence, RI 02903-2699
(401) 459-1000 www.BCBSRI.com

Physician/Provider Notification of Hospital Privileges

THIS FORM MUST BE COMPLETED AND RETURNED

Please select ONE of the following options and sign/date at the bottom:

1. ____I wish to participate/continue my participation with Blue Cross & Blue Shield of Rhode Island (BCBSRI). I understand that all referrals and services for BCBSRI members must be directed to a participating hospital for the member to receive full benefits. I have privileges at:

Primary Hospital Name _____ Effective Date _____

Additional(s) Hospital Name _____ Effective Date _____

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2. ____I wish to participate/continue my participation with BCBSRI. I understand that all services for BCBSRI members shall be directed to participating facilities and physicians and have made arrangements for a participating BCBSRI physician/provider to admit to a participating hospital on my behalf. This arrangement is as follows:

Participating Physician/Provider Name: _____

Participating Hospital Name: _____

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3. ____ This is not applicable since I am a hospital-based physician/provider working on a referral basis/not admitting patients.

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4. _____ I do not have privileges at a BCBSRI participating hospital nor do I have arrangements with another participating BCBSRI provider to admit on my behalf. However, I would like to be given the opportunity to acquire privileges or make arrangements with another participating physician/provider to admit patients on my behalf at a participating BCBSRI hospital. I understand that if I do not comply and notify BCBSRI of my new arrangements I will be terminated in accordance with my contract/denied participation in the BCBSRI network.

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5. _____ I do not have privileges at a BCBSRI participating hospital nor do I have arrangements with another participating BCBSRI provider to admit on my behalf and therefore wish to terminate my participation with BCBSRI for all lines of business.

Physician/Provider Signature _____ Date _____

I hereby authorize BCBSRI and its Medical Director to consult with prior and current associates, administrators, and members of hospital staffs or institutions with which I have been or may be currently associated, as well as professional organizations, and others who may have information bearing on my professional competence, character, ethical qualifications, ability to work cooperatively with others, and other qualifications to be and continue to be a participating physician in the BCBSRI physician network. This release is granted with the understanding that BCBSRI will take responsible measures to maintain the confidentiality of this information.

Rev. 3/29/17