



Authorization Form

All practitioners should complete this section to assure that payments are made under the correct tax/EIN/social security number.

I, the undersigned, duly licensed and registered as a _____ hereby authorize CareFirst of Maryland, Inc. and/or Group Hospitalization and Medical Services, Inc. d/b/a/ CareFirst BlueCross BlueShield and their subsidiaries and affiliates (hereinafter collectively referred to as "CareFirst") to pay those sums which would otherwise be payable to me for my professional services rendered to patients to:

_____ (W-9 Legal Name/Payee Name)

_____ (W-9 Tax Identification Number) _____ (Payee Address)

_____ (Provider Name - printed) _____ (Provider Signature)

_____ (Address for 1099 mailing if different) _____ (Date)

This Authorization shall remain in full force and effect until terminated by me, upon giving thirty (30) days prior written notice of such termination to CareFirst.

If you are new to CareFirst or are applying for a new network, please indicate for which of the following networks you would like to be considered:

MEDICAL:

- Participating Indemnity Network (PAR)
- Preferred Provider Network (PPN or SPP)
- Maryland Point of Service Network (General/Family Practitioners, Internists, Pediatricians Only)
- CareFirst BlueChoice HMO Network (Behavioral Health and Substance Abuse practitioners: do not select BlueChoice; you must contact Magellan Behavioral Health at 1-800-788-4005 option 3.)

DENTAL:

- Dental Participating Provider Network
- Dental Preferred Provider Network
- Dental HMO Network

Please list below the practice name(s) and tax identification number(s) of any additional practice(s):

Practice Name	Tax ID Number
_____	_____
_____	_____
_____	_____