PROVIDER APPLICATION REQUEST FORM

(Non-CAQH participant only)

<table>
<tr><td>Medical License/Certification Number:</td><td colspan="3"></td></tr>
<tr><td>NPI Number:</td><td colspan="3"></td></tr>
<tr><td>Date of Birth:</td><td colspan="3"></td></tr>
<tr><td>Provider Last and First Name:</td><td colspan="3"></td></tr>
<tr><td>Requested Contract Entity:</td><td colspan="3">☐ Blue Shield of California Health Plan
☐ Blue Shield of California Promise Health Plan</td></tr>
<tr><td>Contract Status:</td><td colspan="3">Medical Group Name:
☐ Contract Established/Existing ☐ Contract Pending</td></tr>
<tr><td>Requested Contract Primary Specialty:</td><td></td><td>Requested Contract Secondary Specialty:</td><td></td></tr>
<tr><td rowspan="2">Requested Line of Business:</td><td>☐ Medicare
Medicare #:</td><td>☐ TriWest</td><td>☐ Medi-Cal
MediCal #:</td></tr>
<tr><td>☐ Cal MediConnect</td><td colspan="2">☐ Others</td></tr>
<tr><td>Credentialing Mailing Address:</td><td colspan="3"></td></tr>
<tr><td>Credentialing Contact Name:</td><td colspan="3"></td></tr>
<tr><td>Credentialing Contact Email:</td><td colspan="3"></td></tr>
<tr><td>Credentialing Contact Phone:</td><td colspan="3"></td></tr>
<tr><td>Physical Location(s) (as it will appear on directory. If it is the same as above, type “Same as Above”):</td><td colspan="3"></td></tr>
</table>

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