CareFirst
The CareFirst BlueCross BlueShield family of health care plans.

Essential Community Provider Data Form

The following form is used to verify providers' category (or type) of Essential Community Provider (ECP), eligibility and interest in participating with CareFirst BlueCross BlueShield and/or CareFirst BlueChoice, Inc. ("CareFirst") networks.

Complete the information below and send the form to michael.bishop@carefirst.com or fax to (410) 720-5196.

Is your organization interested in participation in CareFirst's networks? Check one. ☐ Yes ☐ No

ECP Category: _____
(e.g., FQHC, FQHC LAs, Community Health Center, Ryan White, Family Planning, Migrant Health Center, etc.)

Organization Name: _____

Organization Contact: _____

Organization Primary Address: _____

_____

Organization Contact Telephone Number: _____

Organization Contact Email: _____

Number of locations (other than primary noted above):_____

Number of licensed Physicians and their specialty (if applicable):

_____ _____

_____ _____

Number of licensed Certified Nurse Practitioners and their specialty (if applicable):

_____ _____

_____ _____

Number of licensed Limited License Providers (LLP) and their specialty (if applicable):

_____ _____

_____ _____

Scope of Services provided:

_____ _____

_____ _____