Blue Cross Blue Shield Blue Care Network of Michigan

Nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association

Allied Provider Recredentialing Form

	Type 2 National provider identifier	Tax Identification Number

Please complete this form if you are a freestanding radiology center, clinical independent laboratory, durable medical equipment supplier, retail health center or urgent care center recredentialing for Blue Cross Blue Shield of Michigan or Blue Care Network.

Section 1: Demographic data

***denotes a required field**

* Provider name	
* What type of provider are you?	☐ Clinical independent laboratory ☐ Durable medical equipment supplier ☐ Freestanding Radiology Center ☐ Medicare-approved ambulatory surgical facility ☐ Medicare-approved physiological laborarory ☐ Retail Health Center ☐ Urgent care center ☐ Open for business? ☐ Yes; Date opened: _____ ☐ No; Date to open for business: _____

Section 2: Professional ID's/Required documentation

Provider type	Professional ID
DME PTAN number (attach copy of medicare approval letter)	
Freestanding radiology center Certificate of Need (attach copy)	

Section 2A: Freestanding Radiology Center and Urgent Care Center (UCC) Required Information

***denotes a required field**

Medicare number	Medicaid number
State Partial Hospitalization Psychiatric license number:	
*Medical Director Name	*Medical Director Michigan Professional license
Medical Director Type 1 NPI	Is the facility 100% owned by a hospital? ☐ Yes ☐ No
If Yes is checked please provide: Hospital Name: _____ Hospital Address: _____	
Medical Director Attestations I attest that all personnel practicing in the facility are appropriately licensed in Michigan. I attest that during the prior five year period, there is an absence of fraud and illegal activities against the urgent care center. Medical Director Signature: _____ Date: _____	

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Section 2A: Freestanding Radiology Center and Urgent Care Center (UCC) Required Information continued

Malpractice/insurance *Required for BCN

All hospitals must maintain $5,000,000 of combined single limit professional liability insurance and $5,000,000 of combined single limit general liability insurance or professional liability insurance (which includes general liability coverage) of $5,000,000 combined single limit.
All other facilities must maintain a level of medical liability insurance in the amount of $500,000/$1,000,000 and general liability insurance in the amount of $1,000,000/$2,000,000. Please provide copies of both fact sheets.

Current Professional Liability Coverage (occurrence) _____ (per aggregate) _____

Expiration date:_____ Liability Coverage is renewed: ☐ Annually ☐ Continuous

Current General Liability Coverage occurrence) _____ (per aggregate)_____

Expiration date:_____ Liability Coverage is renewed: ☐ Annually ☐ Continuous

Are physicans, practitioners and professional clinicians covered under the malpractice insurance? ☐ Yes ☐ No

Carrier Name: _____

Please indicate coverage amounts: _____ (per occurrence) _____ (per aggregate)

Accreditation Status *Required

Accredited By:

☐ AAAHC	☐ DNVHC	☐ ADA	☐ CHAP
☐ COA	☐ ACR	☐ TJC	☐ COLA
☐ ACHC	☐ HFAP	☐ CCAC	☐ Public Health Department

☐ Other: _____ Effective date: _____ Expiration date:_____

N/A: If not accredited by one of the above agencies, please provide a copy of your most recent CMS survey or a copy of the CMS Letter showing that your facility is in substantial compliance.

Are the medical staff credentialed through an: ☐ Internal Process ☐ Outside Agency.

If an Outside Agency is used, please provide the Agency's Name: _____

Credentialing Contact Name/Title: _____

Credentialing Contact Phone number: _____ Fax: _____

Credentialing Contact E-mail: _____

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Section 3: Address data

*denotes a required field

Primary office address (must be an address where health care services are rendered and may be published in BCBSM/BCN provider directories)		
*Street address		
*City	*State	*ZIP code
Primary telephone number must be a phone number patients can call to make an appointment.		
*Primary telephone number	Fax number	

Payment/Remit address		
Street address		
City	State	ZIP code

Mailing address		
Street address		
City	State	ZIP code

Primary address – Accessibility	
* Handicap accessibility ☐ Yes ☐ No * Accessible by train ☐ Yes ☐ No * Accessible by bus ☐ Yes ☐ No	
Contact information Please provide the name and contact information of a person who can answer questions about information in this application	
* First name	* Last name
* Telephone number	Fax number
E-mail	Preferred method of contact? ☐ E-mail ☐ U.S. Mail **Click here for explanation**

Primary address – office hours							
Office hours	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Open time							
Close time							

	Type 2 National provider identifier	Tax identification number

Section 3: Address data continued

*denotes a required field

Additonal Location 2 address (must be an address where health care services are rendered and may be published in BCBSM/BCN provider directories)		
*Street address		
*City	*State	*ZIP code
Primary telephone number must be a phone number patients can call to make an appointment.		
*Primary telephone number	Fax number	

Additonal Location 2 address Accessibility

Credentialing Contact Information
Please provide the name and contact information of a person who can answer questions about information for this location.

* First name	*Last name
*Telephone number extension	Fax number
Email	Click here for explanation Preferred method of contact? ☐ Email ☐ US Mail

Additonal Location 3 address (must be an address where health care services are rendered and may be published in BCBSM/BCN provider directories)		
*Street address		
*City	*State	*ZIP code
Primary telephone number must be a phone number patients can call to make an appointment.		
*Primary telephone number	Fax number	

Additonal Location 3 address Accessibility

Credentialing Contact Information
Please provide the name and contact information of a person who can answer questions about information for this location.

* First name	*Last name
*Telephone number extension	Fax number
Email	Click here for explanation Preferred method of contact? ☐ Email ☐ US Mail

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Section 4: Application Attachments/Checklist

Application Attachments/Checklist
____ Copy of Facility License
____ Copy of current Professional and General Liability Insurance
____ Clinical Laboratory Improvement Amendments (CLIA) Certificate
____ Copy of Accreditation Certificate and/or Accreditation Approval Letter
____ If not accredited, most recent copy of CMS recertification survey or a copy of the CMS letter showing substantial compliance for applicable facilities
____ Copy of CMS Medicare Certification Letter for applicable facilities
____ Certificate of Need (CON) required for PET Scanners, MRI, and Megavoltage Radiation Therapy
____ Registration and certificate/inspection information for mammography, x-ray machines & all other ionizing equipment
____ Copy of DEA license (for Substance Abuse facility licensed for Methadone)
____ Copy of BCBSM EON approval (for ASFs only)

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Section 5: Application Signature

I certify that:

- All required certificates and licensures are current and valid
- I understand that BCBSM/BCN may do an on-site survey after review of this application to verify program compliance and to verify the accuracy of any information provided.
- All employed and contracted health care professionals maintain current Michigan licenses or certifications as required for their positions. All staff members are licensed or certified as required for their positions.
- The facility will comply with any requests for information, documentation, or on site review reviews necessary to credential the site.
- I understand the effective date of participation is the date the application is actually approved by BCBSM/BCN and is not the date the application was submitted or received.
- I understand the facility is not eligible to submit claims for payment until it is approved by BCBSM/BCN, both parties sign the agreement(s), and the processing systems are updated.
- Employed and contracted health care professionals are covered under the facility's general liability insurance or maintain professionals liability insurance of $100,000/$300,000 limits.

When Completed

*Print or Type Name	*Practitioner Signature/Title	*Date