Instructions for fax cover sheet

We cannot accept handwritten forms. Do not hand write anywhere on the forms, otherwise processing will be delayed.

To ensure forms are processed timely, please adhere to the following instructions:

1. Enter all information online; press the tab key  after each entry to move from field to field.

- **For individual practitioners**
  - From (Insert name of contact person)
  - Date (MM/DD/YYYY)
  - Type 1 NPI (National Provider Identifier)
  - State license number
  - When adding an individual to an existing group, be sure to fax a group change form

- **For professional group practices and facilities**
  - From (Insert name of contact person)
  - Date (MM/DD/YYYY)
  - Type 2 NPI (National Provider Identifier)
  - Tax identification number

- **For group practices**
  - From (Insert name of contact person)
  - Date (MM/DD/YYYY)
  - Type 2 NPI (National Provider Identifier)
  - Tax identification number

Instructions for document submission

1. Fax cover sheet must be the first page of your form submission.

2. Fax the registration form and attachments (i.e., signature documents) to **1-866-900-0250**. Be sure to fax the registration information separately for each provider. (For example: If you register two or more providers, you must send a fax for each provider. They cannot be bundled into one fax transmission.)

Questions? Call 1-800-822-2761

FAX COVER SHEET FOR DOCUMENTS

IMPORTANT: Attach this page to the top of your document to avoid processing delays.

Fax To: **866-900-0250 Provider Enrollment**

From:

Date:

Form Number: 10583

Type 2 NPI:

Tax Identification Number:

Blue Cross Blue Shield Blue Care Network of Michigan

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

NEW ALLIED PROVIDER ENROLLMENT FORM

Type 2 National Provider Identifier	Tax Identification Number

Please complete this form if you are an ambulance, ambulatory surgical center, clinical independent laboratory, durable medical equipment supplier, freestanding radiology center, optician/optometric supplier, orthotic prosthetic, prosthetic and orthotic supplier (with a facility accreditation), retail health center, urgent care center or vaccine pharmacy applying to Blue Cross Blue Shield of Michigan and Blue Care Network for the first time.

If you are a Medicare approved ambulatory surgical center/facility or a physiological laboratory please complete this form. This information will be utilized solely for processing Medicare crossover claims and is not intended for BCBSM/BCN standard network claims

Note: If you are an orthotic, prosthetic, prosthetic and orthotics supplier with an individual certification, please complete the New Allied Provider Enrollment form.

Section 1: Demographic Data

*denotes a required field

*Provider name	
What type of provider are you?	☐ Ambulance ☐ Clinical independent laboratory ☐ Durable medical equipment supplier ☐ Freestanding radiology center ☐ Independent diagnostic testing facility ☐ Optician/optometric supplier ☐ Orthotic supplier ☐ Private Duty Nursing ☐ Prosthetic supplier ☐ Prosthetic and orthotic supplier ☐ Vaccine pharmacy ☐ Medicare-approved ambulatory surgical facility ☐ Medicare-approved physiological laboratory ☐ Retail health center ☐ Urgent care center ☐ Open for business? (UCC must be open for business prior to enrollment with the Blues) **Required fields:** ☐ Yes; Date opened: ☐ No; Date opened for business:
*County where your primary address is located	

Section 2: EIN/Tax information

*EIN/Tax ID number	
*EIN/Tax name as indicated on Internal Revenue Services document	
*Tax exempt?	☐ Yes ☐ No
Are you considered an Essential Community Provider under the Affordable Care Act?	☐ Yes ☐ No
Medicare/PTAN number	

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Section 3: Requested networks

You will be notified of your status and the effective dates of affiliation in BCBSM and BCN's managed care networks after credentialing for the networks is completed and BCBSM and BCN have countersigned your Affiliation Agreements. **Important: Along with this application, it is necessary to complete and submit the signature document appropriate for your provider type. For each network you wish to participate in, be sure to place a check mark by the appropriate affiliation agreement, sign the signature document, and submit it along with this form.**

BCBSM and BCN do not permit retroactive effective dates in managed care networks.

Select networks you are applying to:

Provider Type	Eligible Networks for Provider Type	
Ambulance	☐ Traditional-Participating ☐ Traditional-Nonparticipating ☐ Medicare Advantage℠ PPO	☐ BCN Commercial ☐ BCN Advantage℠ HMO
Clinical independent laboratory	☐ Traditional-Participating ☐ Traditional-Nonparticipating	
Durable medical equipment supplier Orthotic supplier Prosthetic supplier Prosthetic supplier and Orthotic supplier	☐ Traditional-Participating ☐ Traditional-Nonparticipating	
Independent diagnostic testing facility	☐ Medicare Supplemental	
Physiological laboratory	☐ Medicare Supplemental	
Private Duty Nursing	☐ Traditional-Participating ☐ Traditional-Nonparticipating	☐ TRUST PPO
Retail health center	☐ Traditional-Participating ☐ Traditional-Nonparticipating	☐ BCN Commercial ☐ BCN Advantage℠ HMO
Urgent care	☐ Traditional-Participating ☐ Traditional-Nonparticipating ☐ Medicare Supplemental	☐ BCN Commercial ☐ BCN Advantage℠ HMO
Freestanding radiology center	☐ Traditional-Participating ☐ Traditional-Nonparticipating ☐ Medicare Supplemental	☐ BCN Commercial ☐ BCN Advantage℠ HMO
Vaccine pharmacy	☐ Traditional-Participating ☐ Traditional-Nonparticipating	☐ BCN Commercial ☐ TRUST PPO
Optician/Optometric Supplier	☐ Vision-Participating	☐ Vision-Nonparticipating

NEW ALLIED PROVIDER ENROLLMENT FORM

Type 2 National Provider Identifier	Tax Identification Number

Section 4: Professional ID's/Required documentation

Provider type	Professional ID
Ambulance license number (ground) (attach copy)	
Ambulance FAA number (air) (attach copy) and certificate of need (CON)	
DME PTAN number (attach copy of Medicare approval letter)	
Freestanding radiology center certificate of need (CON) (attach copy)	
Laboratory CLIA number (attach copy of the certificate)	
Orthotic, prosthetic, prosthetic and orthotic supplier (attach a copy of accrediting organization certification)	
Medicare-approved independent diagnostic testing facility PTAN number (attach copy of Medicare approval letter)	
Medicare-approved ambulatory surgical facility PTAN number (attach copy of Medicare approval letter)	
Medicare approved physiological laboratory PTAN number (attach copy of Medicare approval letter)	

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NEW ALLIED PROVIDER ENROLLMENT FORM

Type 2 National Provider Identifier	Tax Identification Number

Section 4: Freestanding Radiology Center (FRC), Retail Health Center, Urgent Care Center (UCC) and Private Duty Nursing Required Information

Medical Director Name	Medical Diretor 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

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

If Outside Agency is used please provide the agency's name: _____

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: _____

Private Duty Nursing: Are you affiliated with a Home Health Care Provider: ☐ Yes ☐ No

If ***yes***, Name: _____ NPI: _____ Tax ID: _____

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NEW ALLIED PROVIDER ENROLLMENT FORM

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Section 4A: Freestanding Radiology Center (FRC), Retail Health Center, Urgent Care Center (UCC) and Private Duty Nursing Required Information *(continued)*

Malpractice Insurance

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 Medical 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 physicians, practitioners and professional clinicians covered under the malpractice insurance? ☐ Yes ☐ No

Carrier Name:

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

Accreditation Status

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.

Credentialing Contact Name/Title: _____

Credentialing Contact Phone Number: _____ Fax: _____

Credentialing Contact Email: _____

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NEW ALLIED PROVIDER ENROLLMENT FORM

Type 2 National Provider Identifier	Tax Identification Number

Section 4A: Freestanding Radiology Center (FRC), Retail Health Center, Urgent Care Center (UCC) and Private Duty Nursing Required Information *(continued)*

Freestanding Radiology Center (FRC) Please indicate specific services that have changed.			
CT Scan	☐ Add ☐ Remove	Cardiac Stress Testing	☐ Add ☐ Remove
Nuclear Medicine	☐ Add ☐ Remove	Bone Density	☐ Add ☐ Remove
X-ray	☐ Add ☐ Remove	Fluoroscopy	☐ Add ☐ Remove
PET scan	☐ Add ☐ Remove	MRI - Open	☐ Add ☐ Remove
MRI	☐ Add ☐ Remove	Mammography	☐ Add ☐ Remove
MRI of Breast	☐ Add ☐ Remove	Echocardiography	☐ Add ☐ Remove
Ultrasound	☐ Add ☐ Remove		

Urgent Care Center (UCC) Please indicate specific services that have changed.			
Casting	☐ Add ☐ Remove	On-site Defibrillator	☐ Add ☐ Remove
Splinting	☐ Add ☐ Remove	Laceration repair	☐ Add ☐ Remove
On-site Lab	☐ Add ☐ Remove	On-site Crash cart	☐ Add ☐ Remove
CLIA Waived Rapid Tests	☐ Add ☐ Remove	On-site X-ray	☐ Add ☐ Remove
Stitching	☐ Add ☐ Remove		

If On-site X-ray was selected, does a Board Certified Radiologist read the x-rays? ☐ Yes ☐ No

List the name of Radiologist or Radiology Group who reads the x-rays:

_____

Is there a physician onsite at all times? ☐ Yes ☐ No

Is there an ACLS certified practitioner onsite at all times: ☐ Yes ☐ No

What is the staffing ratio for this site? (Staff: MD) _____

Identify total number of staff who works at this site, as well as number of staff per shift:

Staff Type	Total	Per Shift
MD		
PA		
RN		
ER RN		
Med Asst.		
Other (Specify)		

Does this site also have a physician practice that accepts referrals or provides primary care services? ☐ Yes ☐ No

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Section 4B: Durable Medical Equipment Supplier, Orthotic Supplier, Prosthetic Supplier, Prosthetic and Orthotic Supplier Required Information

Please indicate specific services provided:

Ambulatory aids	☐ Add	☐ Remove
Commodes, Urinals, Bedpans	☐ Add	☐ Remove
Braces, off the shelf	☐ Add	☐ Remove
Braces, custom	☐ Add	☐ Remove
Breast prostheses and accessories	☐ Add	☐ Remove
Breast pumps	☐ Add	☐ Remove
Compression stockings, Off the shelf	☐ Add	☐ Remove
Compression stockings, Custom	☐ Add	☐ Remove
Diabetic shoes and inserts	☐ Add	☐ Remove
Continuous Positive Airway Pressure devices and supplies (CPAP)	☐ Add	☐ Remove
Continuous Passive Motion Devices (CPM)	☐ Add	☐ Remove
Custom wheelchair seating and positioning	☐ Add	☐ Remove
Customized limb prostheses	☐ Add	☐ Remove
Enteral nutrients, equipment, and supplies	☐ Add	☐ Remove
Diabetic testing meters and supplies, mail order	☐ Add	☐ Remove
Diabetic testing meters and supplies non-mail order	☐ Add	☐ Remove
Dynamic splints	☐ Add	☐ Remove
Hospital beds	☐ Add	☐ Remove
Incontinence and urological supplies	☐ Add	☐ Remove
Nebulizers and supplies	☐ Add	☐ Remove
Negative Pressure Wound Therapy Pumps and Supplies	☐ Add	☐ Remove
Orthotic shoes inserts, off the shelf	☐ Add	☐ Remove
Orthotic shoe inserts, custom	☐ Add	☐ Remove
Ostomy supplies	☐ Add	☐ Remove
Oxygen supplies and equipment	☐ Add	☐ Remove
Surgical Dressings	☐ Add	☐ Remove
Transcutaneous Electrical Nerve Stimulators (TENS) and	☐ Add	☐ Remove
Tracheostomy Supplies	☐ Add	☐ Remove
Ventilators, accessories and supplies	☐ Add	☐ Remove
Wheelchairs (power and manual) and accessories	☐ Add	☐ Remove

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Section 5: Address data

Primary 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
Payment/Remit telephone number *(if different from your Primary telephone number)*		

Mailing address		
*Street Address		
*City	*State	*Zip Code
*Mailing contact name	*Mailing contact phone number	

Medical Records Request (MRR)		
Street Address		
City	State	Zip Code
Contact Name - First	Middle	Last
Telephone	Fax	Email

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Section 5: Address data *(continued)*

Primary address - Accessibility							
*Handicap accessibility: ☐ Yes ☐ No *Accessible by bus: ☐ Yes ☐ No							
Primary address - office hours							
Office Hours	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Open Time							
Close Time							
Do you provide 24/7 coverage at this location? ☐ Yes ☐ No							

Urgent Care Providers Only:	
Does the facility offer extended hours of operation, which are prior to 9 a.m., after 4 p.m. or weekend hours and total a minimum of 24 hours per week	☐ Yes ☐ No

Section 6: Contact Information

*denotes a require field

Note: 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	extension		Fax number
Email			Preferred method of contact? ☐ Email ☐ U.S. Mail

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Section 7: Application Signature

*denotes a require field

Has any member of the group ever been convicted of, pled guilty to, or pled nolo contendere to any felony?

☐ No ☐ Yes (Insert nature of offenses)

In the past ten years has any member of the group been convicted of, pled guilty to, or pled nolo contendere to any misdemeanor (excluding minor traffic violations) or been found liable or responaible for any civil offense that is reasonably related to your qualifications, competence, functions, or duties as a medical professional, or for fraud, an act of violence, child abuse or a sexual offense or sexual misconduct?

☐ No ☐ Yes (Insert nature of offenses)

I certify that the information contained in this application is true and complete. I will notify Blue Cross Blue Shield of Michigan and Blue Care Network immediately in writing of changes affecting this data. If I am a practitioner in training, I will not report services that are related to my training program and rendered at the address from which I am training. Should I re-enter training, I will notify BCBSM and BCN.

For providers applying to be Traditional non-participating providers, the authorized signer agrees on behalf of itself and the provider on whose behalf the authorized signer is acting, to adhere to BCBSM's Billing Guidelines for Non-Participating Providers. These Guidelines include, without limitation, the requirement to permit BCBSM or its designee physical access to the provider's premises to review and/or copy for any permissible purpose any and all medical and billing records submitted by the provider or its billing agent; and the requirement that the provider accept BCBSM's payment as payment in full for services rendered to a BCBSM member when the provider has indicated that it will accept assignment of payment on the member's behalf, will participate with BCBSM on a particular claim, or has otherwise indicated that he/she wishes to receive payment directly from BCBSM and, with the exception of any applicable deductibles, co-payments, or co-insurance amount, not balance bill the member for the difference between BCBSM's payment and the provider's charged amount.

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