Hospital Application

Thank you for interest in participating in Blue Cross Blue Shield of Michigan (BCBSM) and/or Blue Care Network (BCN) hospital provider networks/programs! Please review the Requirements listed on the next page. If you believe you meet the requirements, please proceed to Section 1 and complete the application in its entirety. Please type the information required in the space provided.

There are network descriptions and additional detailed information in Appendices at the back of the application. We encourage you to read through that information. Please note that Long-Term Acute Care Hospitals are separately contracted with BCBSM and require separate facility codes.

Please submit all necessary documentation with the application. Section 11 outlines all of the required documents and can be used as a checklist when submitting your application. Please return the completed application and attachments to:

Hospital Program
Provider Contracting Department, MC 513F
Blue Cross Blue Shield of Michigan
600 E. Lafayette Blvd.
Detroit, Michigan  48226-2998

If you need further assistance or have any questions, please contact:

<table>
<thead>
<tr>
<th>For BCBSM</th>
<th>For BCN</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Eric Kropfreiter</strong></td>
<td><strong>Dan Skrzypek</strong></td>
</tr>
<tr>
<td>E-mail: <a href="mailto:EKropfreiter@bcbsm.com">EKropfreiter@bcbsm.com</a></td>
<td>E-mail: <a href="mailto:DSkrzypek@bcbsm.com">DSkrzypek@bcbsm.com</a></td>
</tr>
<tr>
<td>Telephone: 313-448-7892</td>
<td>Telephone: 734-887-5415</td>
</tr>
<tr>
<td>Fax: 877-282-1496</td>
<td>Fax: 866-524-7126</td>
</tr>
</tbody>
</table>
In order to participate with BCBSM and/or BCN to provide short term acute care or psychiatric care to its members, a hospital must, at minimum, have and maintain the following:

- Licensure by the state of Michigan as an acute care hospital and/or psychiatric hospital, as applicable
- If the hospital is licensed as an acute care hospital and also provides inpatient (or Partial) psychiatric care services, hospital must have appropriate licensure by the state of Michigan to provide such psychiatric care.
- Medicare certification appropriate to the services provided
- Accreditation by an accreditation agency acceptable to BCBSM/BCN which includes the following: the Joint Commission, the American Osteopathic Association (AOA), the Commission on Accreditation of Rehabilitation Facilities (CARF) or Det Norske Veritas (DNV) accreditation. DNV applies to acute care only. For hospitals located in a rural census category, accreditation may be waived by BCBSM/BCN at the request of the hospital if the hospital can demonstrate that CMS certified the hospital's compliance with Medicare certification requirements on the basis of a survey conducted by an appropriate state agency.
- Comply with applicable Certificate of Need requirements of the Michigan Public Health Code
- A governing body that is legally responsible for the conduct of the hospital
- A governing body, or advisory body responsible to the governing body, that includes persons generally representative of the community in Hospital's service area
- Follow generally accepted accounting principles and practices
- Programs of utilization management and quality assessment
- An absence of inappropriate utilization or practice patterns as identified through valid subscriber complaints, medical necessity audits, peer review, and utilization management
- An absence of fraud and illegal activities
- Appropriate professional liability and comprehensive general liability insurance or funded self-insurance if the hospital wishes to be considered for affiliation in BCBSM's TRUST (PPO/POS) Hospital Network or BCBSM's Medicare Advantage PPO network. If the hospital wishes to be considered for affiliation in BCN's Commercial HMO and/or BCN Advantage networks, it must maintain a level of medical liability insurance of $1,000,000/$3,000,000 limits and general liability insurance in the amount of $1,000,000/ $2,000,000.

Note: It is BCBSM/BCN's policy to recredential participating providers every 3 years to verify continued compliance with all qualification requirements.
Section 1: NETWORK SELECTION

Select the network(s)/program(s) you are applying to (see network descriptions in Appendix 1 for further details on the networks/programs):

BCBSM Networks
- ☐ Traditional
- ☐ TRUST (PPO)
- ☐ Medicare Advantage PPO
- ☐ Medicare Supplemental
- ☐ Mental Health and Substance Abuse Managed Care Network (SOM Network)

BCN Networks
- ☐ Commercial HMO
- ☐ BCN Advantage

Section 2: TAX ID and NPI INFORMATION

Main inpatient campus

Tax Name (as filed with the IRS):

Hospital Business Name (dba) for directory:

Federal Tax ID#:

Check applicable field: ☐ For profit  ☐ Nonprofit/Tax Exempt

Fiscal Year End (MM/DD/YEAR):

Hospital’s website (URL), if applicable

Acute Care License #: State License Issue Date:

Psychiatric License #: State License Issue Date:

Partial Psychiatric License #: State License Issue Date:

Medicare Acute Care Hospital #: CMS Effective Date:

Medicaid Acute Care Hospital #: Effective Date:

Enter the NPI numbers associated with the hospital’s Tax ID (attach additional sheet, if necessary):

(acute care)

(Medicare exempt psychiatric care unit, if applicable)

(Medicare exempt rehabilitation care unit, if applicable)

(Hospital-based Ambulance)

(Hospital-based ESRD)

(Hospital-based swing beds)

(Hospital-based Clinics)

(Other; describe: )

(Other; describe: )
If applicable, does the hospital use its psychiatric care unit NPI for its partial psychiatric program?

☐ Yes    ☐ No

Does the hospital employ physicians?

☐ Yes    ☐ No

If yes, do the employed physicians bill under the same tax ID as the hospital?

☐ Yes    ☐ No

If no, indicate the tax ID(s) and NPI(s) that they use:

Tax ID__________________________________  NPI________________________________________

Tax ID__________________________________  NPI________________________________________

Does the hospital utilize any other Tax IDs to do business?

☐ Yes    ☐ No

If yes, please list the tax ID(s) and associated NPI numbers:

Tax ID__________________________________  NPI________________________________________

Tax ID__________________________________  NPI________________________________________

Section 3: ADDRESSES/CAMPUSES

Main inpatient campus

Site Address:______________________________________________________________

City: __________________ State: _______ Zip Code: __________County: __________

Phone #: (_____ )________________________ Fax #: (_____ )___________________

Does this campus have an active emergency room?

☐ Yes    ☐ No

Does this campus offer Urgent Care services in a “Center” that is “physically attached” to main campus?

☐ Yes    ☐ No

Mailing Address (if different from site address): ________________________________________________________________

City: ________________ State: _____ Zip Code: __________County: ________________

Mailing Contact Name/Title: ________________________________________________________________

Mailing Contact Phone #: (_____ )________________ Mailing Contact Fax #: (_____ )___________________

Remit Address: ________________________________________________________________

City: ________________ State: _____ Zip Code: __________County: ________________

Remit Contact Name/Title: ________________________________________________________________

Remit Contact Phone #: (_____ )________________ Remit Contact Fax #: (_____ )___________________
**Secondary inpatient campus**

Hospital Business Name (dba) for directory:______________________________

Site Address:__________________________________________________________

City: ________________ State: _______ Zip Code: __________ County: __________

Phone #: (_______) __________________ Fax #: (_______)

NPI (if different from main campus):_______________________________________

Does this campus have an active emergency room?  □ Yes □ No

Does this campus offer Urgent Care services in a “Center” that is “physically attached” to main campus?  □ Yes □ No

*Please attach an additional page if you have more inpatient campus addresses under the same Tax ID and license as the primary/main campus. Be sure to include all requested information above (name, NPI, addresses, etc).

### Section 4: OWNERSHIP

Is the hospital part of a larger healthcare organization?  □ Yes □ No

If “Yes,” provide the name of the healthcare organization:

_________________________________________________________________________________

What is the hospital’s relationship to this larger healthcare organization?

□ Affiliation

□ Management contract

□ Joint Operating Agreement

□ Wholly owned subsidiary

□ Other, please list ______________________________________________

List the following information for the hospital if it is owned by an individual(s).  Attach additional pages if necessary.

Name: ____________________________________________ Ownership___%  
Home Address: ____________________________________  
Occupation: ______________________________________

Name: ____________________________________________ Ownership___%  
Home Address: ____________________________________  
Occupation: ______________________________________

Name: ____________________________________________ Ownership___%  
Home Address: ____________________________________  
Occupation: ______________________________________
Provide the following information for the hospital if an organization owns it or has managing control (e.g., corporation, governmental and/or tribal organizations, partnerships and limited partnerships, charitable and/or religious organizations, etc.). Attach additional pages if necessary.

<table>
<thead>
<tr>
<th>Organization's name</th>
<th>Percent ownership (if applicable)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Ownership ___%</td>
</tr>
<tr>
<td></td>
<td>Ownership ___%</td>
</tr>
<tr>
<td></td>
<td>Ownership ___%</td>
</tr>
</tbody>
</table>

Has the hospital or an officer, director, owner (e.g., individuals or parent organizations) or principal (those with significant authority and responsibility) of the hospital ever had any convictions, guilty pleas, nolo contendere pleas, remands to diversion programs, civil judgments or settlement of civil actions that are related to the provision or payment of health care services? □ Yes □ No

If “Yes,” please explain:

________________________________________________________________________________
________________________________________________________________________________

Has the hospital or its owner(s) (e.g. individuals or parent organizations) ever been subject to a Corporate Integrity Agreement or been found to have been non-compliant with self-dealing and/or anti-kickback laws and regulations? □ Yes □ No

If “yes” please provide a complete explanation below and/or attach additional pages if necessary

________________________________________________________________________________

Section 5: STAFFING

State the name, phone number and e-mail address of the following hospital officers/staff:

<table>
<thead>
<tr>
<th>Officer/Director</th>
<th>Name</th>
<th>Phone Number</th>
<th>E-Mail Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chief Operating Officer</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chief Executive Officer</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Chief Financial Officer</td>
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<td></td>
<td></td>
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<tr>
<td>Director of Reimbursement</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Director of Utilization Management &amp; Quality Improvement</td>
<td></td>
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</tbody>
</table>
### Officer/Director

<table>
<thead>
<tr>
<th>Name</th>
<th>Phone Number</th>
<th>E-Mail Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Director</td>
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</tbody>
</table>

Medical Director License No.: ____________________________________________

Medical Director Credentials (MD, DO; Specialty): __________________________________

Nursing Director Name: ____________________________ License No.: ________________

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

If an Outside Agency was used, please provide the name of the Agency:
_________________________________________________________________________________

Credentialing Contact Name/Title: _____________________________________________________

Credentialing Contact Phone#: (_______)________ Credentialing Contact Fax #: (_______)_________

Credentialing Contact Email: ________________________________________________________

Does the hospital have a governing or as an alternative, a community advisory board responsible to the governing board, that is legally responsible for the total operation of the hospital and for ensuring that quality care is provided in a safe environment?  
☐ Yes  
☐ No

Does the governing or advisory board include persons representative of a cross section of the community?  
☐ Yes  
☐ No

Does the hospital have a Graduate Medical Education program?  
☐ Yes  
☐ No

If “Yes, indicate the number of direct and/or indirect Full Time Equivalents (FTEs) for the hospital’s GME program.

FTE interns & residents (direct): ___________  FTE interns & residents (indirect): _____________

### Section 6: ACCREDITATION/CERTIFICATIONS

Check all accreditation(s) applicable to the hospital:

<table>
<thead>
<tr>
<th>Check</th>
<th>Accreditation</th>
<th>Effective Date</th>
<th>Expiration Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐</td>
<td>The Joint Commission</td>
<td></td>
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<tr>
<td>☐</td>
<td>AOA - American Osteopathic Association</td>
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<td></td>
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<tr>
<td>☐</td>
<td>CARF – Commission on Accreditation of Rehabilitation Facilities</td>
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<tr>
<td>☐</td>
<td>DNV (acute care only - does not apply to inpatient psychiatric care)</td>
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<tr>
<td>☐</td>
<td>Other (Specify)</td>
<td></td>
<td></td>
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<tr>
<td>☐</td>
<td>None (provide explanation below)</td>
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<td></td>
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</tbody>
</table>

_________________________________________________________________________________

_________________________________________________________________________________

WP 13084 AUG 15
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 hospital has Medicare certification based upon the state of MI survey.

Check all applicable Medicare and Medicaid designations/certifications that apply to the hospital:

<table>
<thead>
<tr>
<th>Medicare Designations/Certifications</th>
<th>Yes</th>
<th>No</th>
<th>If yes, CMS certification number</th>
<th>If Yes, CMS effective date (MM/DD/YEAR)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children’s Hospital (excluded PPS)</td>
<td></td>
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<tr>
<td>Critical Access Hospital</td>
<td></td>
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<tr>
<td>Exempt Psychiatric Unit or Psychiatric Hospital (excluded from PPS)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Exempt Rehabilitation Unit or Rehabilitation Hospital (excluded from PPS)</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medicare Dependent Hospital</td>
<td></td>
<td></td>
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<tr>
<td>Rural Referral Center</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Short-Term (General &amp; Specialty) Hospital</td>
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<tr>
<td>Sole Community Hospital</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Swing beds</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital Based - End Stage Renal Dialysis</td>
<td></td>
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<td></td>
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<tr>
<td>Other (specify)</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Other (specify)</td>
<td></td>
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</tr>
</tbody>
</table>

Has the hospital’s license(s) or any of the hospital’s Medicare certifications ever been revoked, suspended or terminated for hospital services, or has the hospital or any of its owners ever been an excluded entity or an excluded individual from state or federal programs? □ Yes □ No

If "Yes," provide a complete explanation below (attach additional pages if needed).

__________________________________________________________________________________
__________________________________________________________________________________

**Section 7: MALPRACTICE / INSURANCE**

Hospital must maintain appropriate professional liability and comprehensive general liability insurance of funded self-insurance if the hospital wishes to be considered for affiliation. If the hospital wishes to be considered for affiliation in BCN’s Commercial HMO and BCNA Advantage networks, it must maintain a level of medical liability insurance limits of $1,000,000/$3,000,000 limits and general liability insurance limits of $1,000,000/$2,000,000.

Current General Liability coverage (occurrence) ______________(per aggregate)_____________
Expiration Date: ______________ Liability Coverage is renewed: □ Annually □ Continuous

Current Medical Liability coverage (occurrence) ______________(per aggregate)_____________
Expiration Date: ______________ Liability Coverage is renewed: □ Annually □ Continuous

Are hospital employed physicians, practitioners and professional clinicians covered under the malpractice insurance?
□ Yes □ No

Carrier Name(s): ___________________________
Section 8: SERVICES/PROGRAMS

Does the hospital assess the quality of care rendered to patients to assure that proper services are provided at the proper time by qualified individuals? □ Yes □ No

Does the hospital identify, refer, report and follow up on quality of care issues and problems? □ Yes □ No

Does the hospital monitor all aspects of patient care delivery? □ Yes □ No

Does the hospital have beds allocated and staffed for a unit specifically designated for severe burn care? □ Yes □ No

   If “Yes,” indicate the number of burn unit beds in use/operation __________

Does the hospital have beds allocated and staffed for a unit specifically designated as a trauma unit? □ Yes □ No

   If “Yes,” indicate the number of trauma unit beds in use/operation __________

Does the hospital have beds allocated and staffed for a unit specifically designated for Neonatal intensive Care? □ Yes □ No

   If “Yes,” indicate the number of NICU beds in use/operation __________

Does the hospital have beds allocated and staffed for a unit specifically designated as inpatient rehabilitation unit? □ Yes □ No

   If “Yes,” indicate the number of acute rehabilitation beds in use/operations ______

Does the hospital have beds allocated, staffed, and licensed for a unit specifically designated for psychiatric care? □ Yes □ No

   If “Yes,” indicate the number of psychiatric care beds in use/operations ______

   If “Yes,” indicate the number of psychiatric partial beds in use/operations ______
From the following menu, please insert the corresponding number for the inpatient specialty each hospital campus is recognized for:

<table>
<thead>
<tr>
<th>Speciality</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Acute Care (short term general)</td>
</tr>
<tr>
<td>4. Children’s Hospital</td>
</tr>
<tr>
<td>7. Psychiatric Hospital/Unit</td>
</tr>
<tr>
<td>2. Rehabilitation Hospital/unit</td>
</tr>
<tr>
<td>5. Bariatric Hospitals</td>
</tr>
<tr>
<td>8. Partial Psychiatric Hospital</td>
</tr>
<tr>
<td>3. Surgical Hospital</td>
</tr>
<tr>
<td>6. Cancer Hospital</td>
</tr>
<tr>
<td>9. Veteran</td>
</tr>
<tr>
<td>10. Other</td>
</tr>
</tbody>
</table>

**Inpatient Services/Programs**

<table>
<thead>
<tr>
<th>Main Campus</th>
<th>Second Campus</th>
<th>Third Campus</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td></td>
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</tbody>
</table>

Please place a check mark in the appropriate field(s) if the hospital provides psychiatric services:

**Psychiatric Levels of Care**

<table>
<thead>
<tr>
<th>Description</th>
<th>Child (0-12)</th>
<th>Adolescent (13-17)</th>
<th>Adult (18-64)</th>
<th>Geriatric (65+)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Mental Health</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Outpatient Mental Health</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Partial Psychiatric Care Program</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

**Substance Abuse Levels of Care**

<table>
<thead>
<tr>
<th>Description</th>
<th>Child (0-12)</th>
<th>Adolescent (13-17)</th>
<th>Adult (18-64)</th>
<th>Geriatric (65+)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Substance Abuse - Acute Detox</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Outpatient Substance Abuse – Detox Drug</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Outpatient Substance Abuse – Detox Alcohol</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Inpatient Substance Abuse – Residential</td>
<td>☐</td>
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<td>☐</td>
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</tr>
</tbody>
</table>

**Psychiatric Specialty Services**

- ☐ Inpatient Electroconvulsive Therapy
- ☐ Outpatient Electroconvulsive Therapy
- ☐ 23-Hour Observation
Section 9: FINANCIAL AND BILLING INFORMATION

Does the hospital maintain records of transactions that conform to generally accepted accounting principles? ☐ Yes ☐ No

Are billing charges uniformly applied? That is, for identical services is the charge the same for all Patients? ☐ Yes ☐ No

If "No," provide an explanation:
_________________________________________________________________________________

In the past five years, has the hospital filed a petition for relief under the U.S. Bankruptcy Code, or has any action been taken to dissolve, liquidate, terminate, consolidate, merge or sell all or substantially all of the hospital's assets? ☐ Yes ☐ No

If "Yes," provide an explanation:
_________________________________________________________________________________

Does the hospital have management contract(s) with an outside organization for the provision of core services (e.g., administrative services, staffing services, personnel management, etc)? ☐ Yes ☐ No

If "Yes," please provide the name of the organization and describe the services provided by this outside organization in the space provided below. BCBSM may request a copy of the management contract at a later date.
__________________________________________________________________________________

Section 10: ATTESTATION

I certify by my signature the following:

– The information contained in this application is complete and accurate at the time of submission.

– All required accreditation(s), Medicare certifications and licenses are current and valid

– The hospital must have an organized medical staff, established in accordance with policies and procedures developed by the hospital, which will be responsible for maintaining proper standards of medical care. Criteria for membership on the medical staff must be established and enforced by a credentials evaluation program established by the hospital and approved by BCN.

– Witten criteria for participation on medical staff exist for your hospital

– All employed or contracted health care professionals maintain current State of Michigan licenses or certifications as required for their positions. All staff members are licensed or certified as required for their positions.

– Employed and contracted health care professionals are covered under the facilities general liability or maintain a professional liability insurance of $100,000/$300,000 limits.
- All required policies and procedures have been implemented and are enforced by this hospital.

- Documentation regarding any of the information contained in this application will be produced upon request.

- The hospital will make best efforts to notify BCBSM/BCN of any relevant changes that may occur that would alter the responses provided in this application.

- The hospital will comply with any additional requests for information, documentation, or onsite reviews necessary to credential and/or recredential the site.

- BCBSM/BCN shall be held harmless from any claims, lawsuits, etc. that arises as a result of the misrepresentation of information provided in response to this application.

- I understand and agree that if I am an applicant for BCN, I have the burden of producing adequate information for the proper evaluation of credentials, including professional competence, character, ethics, and other qualifications, and am responsible for resolving any doubts about qualifications.

**Note:** This form must be signed by the person who is responsible for the overall administration and enforcement of policy at your hospital.

Signature: __________________________________________ Date: ______________________

Printed Name: ________________________________

Title: ______________________________________ Phone Number: ______________________
Please attach the following documents for all application requests (unless otherwise noted):

- Copy of Hospital’s acute care license (if applicable)
- Copy of Psychiatric Inpatient Hospital license (if applicable)
- Copy of Psychiatric Partial Hospitalization license (if applicable)
- Copy of IRS-generated EIN Notification number tax form (Form 147C or SS4).
- Hospital organizational chart
- Healthcare system’s operating structure and/or organizational chart showing where the hospital falls within the organization (if applicable)
- Copy of Face Sheet or Declaration Sheet of current Professional & General Liability Insurance
- Copy of most current Accreditation Certificate(s)
- Copy of IRS-generated EIN Notification number tax form (Form 147C or SS4).
- If not accredited, enclose a copy of the most recent state survey, or a letter from the state indicating Medicare certification based upon the state of MI survey.
- Most current Medicare Provider Number Letters (e.g, acute care, psych, rehab, ESRD, etc.)
- Registration and certificate/inspection information for mammography, x-ray machines & all other ionizing equipment
- CLIA Certificate
- Signed/Completed Hospital Application

Please also send a photograph of the exterior of your hospital to bcbsmproviderpictures@bcbsm.com for our website if you have not already done so. The photos should be digital and meet these specifications:

- Size: 156 pixels wide x 125 pixels tall
- Resolution between 150 and 300 dots per inch (dpi)
- File type should be .jpg, .bmp or .psd
- There should be no borders around the photo
- File size should be less than 200K
APPENDIX 1 – NETWORK DESCRIPTIONS

BCBSM

Traditional
Traditional participation as a short-term acute care hospital with BCBSM is available on a formal basis. Services must meet the member’s benefit criteria to be payable. Members of other Blue Cross Blue Shield (BCBS) Plans also use BCBSM’s hospital networks, as applicable, when their members receive hospital services in Michigan. Therefore, member benefits, eligibility, and benefit requirements (e.g. preauthorization) should always be verified before providing services. Covered services provided in a non-participating hospital are reimbursed to the member in accordance with the member’s certificate or benefit plan. (The limited benefit is really not true anymore under national health care.)

TRUST Network (PPO)
To affiliate in the TRUST hospital network, a hospital must also participate in the Traditional network and meet additional qualification standards. The TRUST hospital network is for BCBSM and Blue Plan members enrolled in PPO products (e.g. Community Blue PPO, Blue Preferred PPO, Blue Preferred Plus PPO, etc.). PPO members are typically subject to out-of-network cost sharing and/or benefit restrictions if hospital services are not delivered in a TRUST hospital. If the out-of-network hospital also does not participate in the BCBSM Traditional network, reimbursement for covered services is made to members, in accordance with their certificates or benefit plans.

Medicare Advantage PPO
Medicare certified hospitals are eligible to apply for affiliation in the BCBSM Medicare Advantage PPO network which became effective January 1, 2010 for individual and group customers. To participate in the MA PPO network, hospitals must have and maintain all qualification requirements for TRUST hospital participation.

Medicare Supplemental
Patients who have primary coverage through Original Medicare may also have Medicare Supplemental coverage through BCBSM. This benefit, if available to the patient, may provide coverage for payment of applicable Medicare deductibles, copayments and/or for days of care in excess of those paid for by Medicare. In general, the effective date of a hospital's eligibility for payment under the BCBSM Medicare Supplemental program coincides with the effective date of the hospital's Medicare certification. This date may be different than the hospital's Traditional program participation effective date. All hospitals that are approved for participation in BCBSM's Traditional program are approved for Medicare Supplemental payments.

BCBSM’s Mental Health and Substance Abuse Managed Care Network (SOM Network)
BCBSM’s Mental Health and Substance Abuse Managed Care (MHSAMC) network is called the State of Michigan (SOM) Mental Health Network. It is utilized by select BCBSM customer groups that have chosen a managed care program for inpatient and outpatient mental health and substance abuse benefits. For hospitals, this network applies only to inpatient psychiatric and partial psychiatric care. Other benefits are delivered by other provider types (such as Substance Abuse facilities and Outpatient Psychiatric Care facilities). This network is currently used by UAW Retiree Medical Benefits Trust (URMBT) members, Federal Employee Program (FEP) members, Chrysler members, Ford Hourly National PPO Plan members, and Ford Blue Preferred Plus members. This network is currently managed (care preauthorized) by a vendor care manager. Members are subject to out-of-network cost sharing and/or benefit restrictions. For some benefit plans, out-of-network referrals are not allowed and the member has no benefit when receiving services from an out-of-network hospital.
Other Non-Acute BCBSM Provider Classifications
Certain non-acute services that hospitals may provide must be separately contracted (and require separate facility codes) with BCBSM (e.g. separately licensed Ambulatory Surgery Facilities even if CMS considers the ASF provider-based, Home Health Care services, Home Infusion Therapy, Hospice, Outpatient Psychiatric Care facilities, Substance Abuse facilities, and Urgent Care Centers that are not physically attached to the hospital, etc.). Separate applications for these programs, as well as for Long-Term Acute Care Hospitals can also be found in the provider/enrollment section at bcbsm.com. *Reason, technically LTACHs are acute – not non-acute*

BCN

**Commercial HMO**
Blue Care Network offers a Commercial HMO network that includes physicians, hospitals and other medical professionals to provide state-of-the-art health care services for members. BCN offers its members health information, risk assessment tools and special programs to help reach their health and wellness goals.

**BCN Advantage**
BCN Advantage(SM) is Blue Care Network’s Medicare Advantage HMO product. BCN has contracted with the Centers for Medicare & Medicaid Services to provide health care services to Medicare beneficiaries. The BCN Advantage plan is designed to:

- Provider members with all Medicare-covered services
- Offer preventive and wellness care (for example, an annual physical exam) and encourage the Medicare population to use medical services for preventive care
- Limit member cost to a predetermined copayment for Medicare Advantage (Medicare Parts A + B) coverage
- BCN, not Medicare, is the payer for covered health services rendered to a BCN Advantage member, with the exception of hospice care
APPENDIX 2 – ADDITIONAL INFORMATION

Application and Contracting Process

Please be certain that the application is complete and all required attachments are enclosed at the time of submission. It takes approximately two weeks for us to review a complete application. Incomplete applications will significantly delay the approval process.

If the hospital is approved for participation, the applicable participation agreement(s) will be offered. If, however, the hospital would like to review the agreements prior to submitting the application, you may request a sample copy from the applicable BCBSM and/or BCN contact listed on page 1 of this application. Most BCBSM agreements are available as a link in the Participation chapter of the provider manual on web-DENIS. If the hospital is not approved, we will send notification in writing indicating the reason(s) for the denial.

If the hospital is approved and offered one or more hospital agreements, it will be asked to retain the agreement(s) for its records and to return the signed Signature Document(s) to BCBSM/BCN. The countersigned copy of the Signature Document(s) will be returned to the hospital after the BCBSM/BCN hospital facility code, NPI, and appropriate claims system change has been activated for billing purposes, and reimbursement rates are determined. This generally occurs within 15-30 days of our receipt of the signed Signature Document(s).

If the hospital is approved a separate BCBSM hospital facility code will be assigned to the contracted location. With the implementation of National Provider Identifiers (NPI) in 2008, BCBSM crosswalks the claims from the facility’s NPI to the BCBSM facility code (i.e., BCBSM internal identifier) for processing. Therefore, BCBSM recommends obtaining NPI’s in accordance with federal guidelines. Federal guidelines also allow for an NPI to be obtained for unique combinations of tax ID, location and taxonomy (specialty) codes. BCN relies solely on NPI’s for each approved and contracted location.

The effective date for participation in the BCBSM Traditional or TRUST hospital program, or MHSAMC program will be the date the application is approved by BCBSM. It is not retroactive to the date the hospital submitted the application, began providing services, or became licensed, etc. The effective date for participation in the MA PPO network is the date indicated on the Signature Document. The effective date for participation in BCN networks is the date indicated on the final, executed contract.

The hospital may not submit claims and is not eligible for reimbursement unless and until participation is approved by BCBSM/BCN and both parties have signed the applicable agreement(s), and a BCBSM/BCN hospital facility code and NPI is activated.

After the participation agreement(s) has been signed by both parties, the hospital’s provider consultant will mail or deliver a welcome package with information on how to sign up for electronic billing and web-DENIS, a web based information system for providers. Through web-DENIS the hospital will have access to provider manuals, fee schedules, the Magellan criteria manual, newsletters and patient data such as member contract eligibility and benefits. It is the hospital’s responsibility to be familiar with and to adhere to all billing and benefit requirements. It is also the responsibility of the hospital to ensure that its billing department (or billing agency) is compliant with all of billing requirements.
APPENDIX 3 – REIMBURSEMENT

Reimbursement

Hospitals must submit claims electronically to BCBSM/BCN on the electronic equivalent of the UB 04 claim form, in a HIPPA compliant manner, in accordance with our Provider Manuals. Hospitals should contact BCBSM's Electronic Data Input (EDI) Helpline at (800) 542-0945 for electronic billing information after their BCBSM hospital facility code has been received.

Participating hospitals or those that are eligible to receive Medicare Supplemental payments, must notify the BCBSM Provider Contracting department immediately of any change in the hospital’s ownership, tax identification number, address, phone number, Medicare certification number, Medicare certification status, NPI, etc.

BCBSM

Reimbursement to each hospital is determined as defined in the Participating Hospital Agreement (PHA) and in the TRUST Hospital Participation Agreement, and in the BCBSM MA-PPO Hospital Attachment.

MHSAMC Hospital Reimbursement for covered services, BCBSM will pay the lesser of the hospital’s charge or the BCBSM approved amount, less copayments and/or deductibles if applicable. The BCBSM approved amount for these networks is a hospital-specific per-diem for inpatient psychiatric care and/or partial hospitalization care.

If the hospital is approved and contracted as a participating provider in the Traditional and/or TRUST networks, BCBSM's Facility Reimbursement Department will send the hospital appropriate rate information.

Hospitals that are approved for BCBSM Traditional participation will automatically be eligible to receive Medicare Supplemental benefits. Hospitals are generally eligible to begin receiving these payments retroactive to the hospital’s Medicare certification effective date. However, because of claims filing limitations, BCBSM will generally not assign a BCBSM Medicare Supplemental facility code with a retroactive effective date that exceeds a two year time period. Hospitals approved for the Medicare Supplemental-only program will receive a letter confirming their facility code assignment and its effective date.

BCN

Reimbursement to each hospital is stipulated in the BCN Hospital Affiliation Agreements (BCN-HAA) for commercial or Medicare Advantage that are sent under separate cover for each BCN network.

NOTE: The information supplied in this application is general information only and is subject to change without notice. The application does not constitute a provider agreement or a provider manual. Members’ benefit plans will vary.