

Facility Enrollment Form



PLEASE:

1. Complete the application in its entirety.
2. No handwritten forms, please type.
3. This coversheet must be the first page of your form submission.
4. Fax the enrollment form and attachments (i.e. supporting documents) to 1-855-306-9762 or email to bccproviderdata@mibluccrosscomplete.com. Be sure to submit the enrollment form separately for each provider. (For example: if you register two or more providers, you must send a fax/email for each provider. They cannot be bundled into one transmission.)
5. You can also mail the completed forms and documentation to: Blue Cross Complete of Michigan, Provider Network Management, 100 Galleria Officentre; Suite 210, Southfield, MI 48034.
6. Based on your provider type, there are specific sections that must be completed. Please review the enrollment form in its entirety to ensure each required section is completed.
7. Supporting documents checklist is located at the end of the enrollment form, please review and ensure all required documents are submitted along with this enrollment form.

To avoid processing delays, please ensure all fields below are completed					
Fax to:	1-855-306-9762 Attn: Provider Network Management				
Email to:	BCCproviderdata@mibluccrosscomplete.com				
From:					
Date:					
Type 2 NPI:					
Tax identification number:					
Is the provider enrolled in CHAMPS*?	<table border="0" style="width: 100%;"> <tr> <td style="text-align: center;">Yes</td> <td style="text-align: center;">No</td> </tr> <tr> <td style="text-align: center;">If yes, Effective date:</td> <td style="text-align: center;">End date:</td> </tr> </table>	Yes	No	If yes, Effective date:	End date:
Yes	No				
If yes, Effective date:	End date:				
Is the provider already enrolled with Blue Cross Blue Shield of Michigan or Blue Care Network?	<table border="0" style="width: 100%;"> <tr> <td style="text-align: center;">Yes</td> <td style="text-align: center;">No</td> </tr> </table>	Yes	No		
Yes	No				
If "No," you will be provided additional forms for completion and this may delay the enrollment process.					

* Michigan Department of Health and Human Services enrollment system

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Section 1: Demographic data

*denotes a required field

1. *Provider name	
2. *Provider type	<p>Acute Care Hospital</p> <p>Ambulatory Infusion Center</p> <p>Ambulatory Surgical Facility</p> <p>Clinical Independent Laboratory</p> <p>Durable Medical Equipment Supplier</p> <p>End Stage Renal Disease Facility</p> <p>Federally Qualified Health Center</p> <p>Freestanding Radiology Center</p> <p>Home Healthcare Facility</p> <p>Home Infusion Therapy</p> <p>Hospice</p> <p>Independent Diagnostic Testing Facility</p> <p>Long-term Acute Care Hospital</p> <p>Outpatient Physical Therapy Facility</p> <p>Outpatient Psychiatric Center</p> <p>Prosthetic and Orthotic Suppliers</p> <p>Rural Health Clinic</p> <p>Skilled Nursing Facility</p> <p>Urgent Care Center</p>
3. *Tax identification number	
4. *Tax identification name (as filed with the IRS)	
5. *Tax exempt?	<p>Yes No</p>
6. *Providers website (URL address)	
7. *Associated NPI numbers	
8. State license number	
9. Medicaid number	

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Section 2: Address information – please make copies for additional addresses

* denotes required field

1. Practice address (must be an address where health care services are rendered and may be published in the Blue Cross Complete provider directory)	
a. *Street address	
b. *City	
c. *State	
d. *Zip code	
e. County	
f. *Primary telephone number	
g. Fax number	
2. Payment or remit address (if different from your practice address)	
a. Street address	
b. City	
c. State	
d. Zip code	
3. Mailing address (if different from your practice address)	
a. Street address	
b. City	
c. State	
d. Zip code	
4. Medical records request (if different from your practice address)	
a. Street address	
b. City	
c. State	
d. Zip code	

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Section 3: Address information – Accessibility

* denotes required field

1. *Handicap accessible	Yes	No
2. *Accessible by train	Yes	No
3. *Accessible by bus	Yes	No
4. Contact information – please provide the name and contact information of a person who can answer questions about information in this enrollment form		
a. *Contact name		
b. *Telephone number		
c. *Email address		
5. *Office hours		
	From	To
a. Monday		
b. Tuesday		
c. Wednesday		
d. Thursday		
e. Friday		
f. Saturday		
g. Sunday		

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Section 4: Medical Director information

* denotes required field

1. Medical Director name	
2. Medical Director professional license number	
3. Medical Director type 1 NPI	
4. Medical Director attestations	
<p>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 facility.</p> <p>Medical Director signature: _____ Date: _____</p>	

Section 5: Malpractice insurance information

1. Malpractice Insurance		
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.		
a. Current medical liability coverage	Occurrence	Per aggregate
b. Expiration date		
c. Liability coverage is renewed	Annually	Continuous
d. Current general liability coverage	Occurrence	Per aggregate
e. Expiration date		
f. Liability coverage is renewed	Annually	Continuous
g. Are physicians, practitioners and professional clinicians covered under the malpractice insurance?	Yes	No
h. Carrier name		
i. Coverage amounts	Per occurrence	Per aggregate

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Section 6 – Accreditation information

* denotes required field

If not accredited by one the below agencies, please provide a copy of your most recent Center for Medicare and Medicaid Services survey or a copy of the CMS letter showing your facility is in substantial compliance

1. Accredited by	Accreditations Association for Ambulatory Health Care Accreditation Commission for Health Care American College of Radiology American Osteopathic Association Continuing Care Accreditation Commission Community Health Accreditation Program Inc. Council of Accreditation Det Norske Veritas Healthcare Healthcare Facilities Accreditation Program Joint Commission on Accreditation of Healthcare Organizations Public Health Department Other: _____
2. Effective date	
3. Expiration date	

Section 7 – Acute care hospital REQUIRED information

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

1. Does the hospital employ physicians?	Yes	No
2. If yes, do the employed physicians bill under the same Tax ID as the hospital?	Yes	No
3. If no, indicate the tax ID and associated NPI they use:		
a. Tax ID	b. NPI	

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Section 7 – Acute care hospital REQUIRED information – continued

* denotes required field

4. Does the hospital use any other tax IDs to do business?	Yes	No
5. If yes, please list the tax IDs and associated NPI numbers:		
a. Tax ID	b. NPI	
6. Does the main inpatient campus have an active emergency room?	Yes	No
7. Does the main inpatient campus offer urgent care services in a center that is physically attached?	Yes	No
8. Is the hospital part of a larger health care organization?	Yes	No
9. If yes, provide the name of the health care organization		
10. What is the hospital's relationship to this larger healthcare organization?	Affiliation Joint operating agreement Management contract Wholly owned subsidiary Other, please list _____	

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Section 7 – Acute care hospital REQUIRED information – continued

* denotes required field

List the following information for the hospital if it is owned by individuals. Attach additional pages if necessary

11. Name:	
12. Home address	
13. Occupation	
14. Ownership %	
15. Name:	
16. Home address	
17. Occupation	
18. Ownership %	
19. Name:	
20. Home address	
21. Occupation	
22. Ownership %	

Provide the following information for the hospital *if* an organization owns it or has managing control (e.g., corporation, governmental or tribal organizations, partnerships and limited partnerships, charitable or religious organizations). Attach additional pages if necessary.

23. Organization name		24. Ownership %	
25. Organization name		26. Ownership %	
27. Organization name		28. Ownership %	

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Section 7 – Acute care hospital REQUIRED information – continued

* denotes required field

State the name, phone number and email address of the following hospital officers/staff			
Officer/Director	Name	Phone number	E-mail address
29. Chief operating officer			
30. Chief executive officer			
31. Chief financial officer			
32. Director of reimbursement			
33. Director of utilization management & quality improvement			
34. Medical director			
35. Nursing director			
36. Is the medical staff credentialed through an outside agency?	Yes	No	
37. If yes, please provide the name of the Agency			
38. Does the hospital have a governing or as an alternative, a community advisory board responsible to the governing board, which is legally responsible for the total operation of the hospital and for ensuring that quality care, is provided in a safe environment?	Yes	No	
39. Does the governing or advisory board include persons representative of a cross section of the community?	Yes	No	
40. Does the hospital have a graduate medical education program?	Yes	No	
41. If yes, indicate the number of direct and/or indirect Full Time Equivalents for the hospital's GME program.	Direct	Indirect	

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Section 7 – Acute care hospital REQUIRED information – continued

* denotes required field

42. Check all applicable Medicare and Medicaid designations/certifications that apply to the hospital				
Medicare designations /certifications	Yes	No	If Yes, CMS certification number	If Yes, CMS effective date (MM/DD/YYYY)
a. Children’s hospital (excluded from PPS)				
b. Critical access hospital				
c. Exempt psychiatric unit or psychiatric hospital (excluded from PPS)				
d. Exempt rehabilitation unit or rehabilitation hospital (excluded from PPS)				
e. Medicare dependent hospital				
f. Rural referral center				
g. Short-term (general and specialty) hospital				
h. Sole community hospital				
i. Swing beds				
j. Hospital based – end stage renal dialysis				
k. Other (specify)				
43. Have the hospital’s licenses 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		
44. If yes, provide a complete explanation below: (attach additional pages if needed)				

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Section 7 – Acute care hospital REQUIRED information – continued

* denotes required field

45. 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
46. Does the hospital identify, refer, report and follow up on quality of care issues and problems?	Yes		No
47. Does the hospital monitor all aspects of patient care delivery?	Yes		No
48. Does the hospital have beds allocated and staffed for a unit specifically designated for severe burn care?	Yes	# of beds in use/operation _____	No
49. Does the hospital have beds allocated and staffed for a unit specifically designated as a trauma unit?	Yes	# of beds in use/operation _____	No
50. Does the hospital have beds allocated and staffed for a unit specifically designated for Neonatal Intensive Care?	Yes	# of beds in use/operation _____	No
51. Does the hospital have beds allocated and staffed for a unit specifically designated as inpatient rehabilitation unit?	Yes	# of beds in use/operation _____	No
52. Does the hospital have beds allocated, staffed and licensed for a unit specifically designated for psychiatric care?	Yes	# of beds in use/operation _____	No

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Section 7 – Acute care hospital REQUIRED information – continued

* denotes required field

53. Please check the inpatient specialty the hospital is recognized for:	
Acute care	Rehabilitation hospital/unit
Surgical hospital	Children’s hospital
Bariatric hospital	Cancer hospital
Psychiatric hospital/unit	Partial psychiatric hospital
Veteran	Other
54. Does the hospital maintain records of transactions that conform to generally accepted accounting principles?	Yes No
55. Are billing charges uniformly applied? That is, for identical services is the charge the same for all Patients?	Yes No
a. If no, provide explanation:	
56. 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
a. If yes, provide explanation:	

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Section 7 – Acute care hospital REQUIRED information – continued

* denotes required field

57. Does the hospital have management contracts with an outside organization for the provision of core services (e.g., administrative services, staffing services, personnel management)?	<table border="1"> <tr> <td data-bbox="1190 352 1352 510">Yes</td> <td data-bbox="1352 352 1547 510">No</td> </tr> </table>	Yes	No
Yes	No		

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

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Section 8 – Enrollment signature

* denotes required field

I certify that:

- All required certificates and licensures are current and valid.
- The facility must have an organized medical staff established in accordance with policies and procedures developed by the facility 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 facility.
- I understand that Blue Cross Complete may do an on-site survey after review of this application to verify program compliance and the accuracy of any information provided.
- Written criteria for participation of medical staff exist for this facility.
- 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 maintains financial records that conform to generally accepted accounting principles and practices.
- All policies and procedures are implemented and enforced by this facility.
- The facility will comply with any requests for information, documentation or on site review reviews necessary to credential the site.
- The facility conducts program evaluation and utilization review to assess the appropriateness and effectiveness of its programs.
- I understand the effective date of participation is the date the application is actually approved by Blue Cross Complete 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 Blue Cross Complete, both parties sign the agreements and the processing systems are updated.
- I understand Blue Cross Complete’s payment rates and the terms of its standard participation agreement are not negotiable.
- Blue Cross Complete shall be held harmless for any claims and lawsuits that arise as a result of the misrepresentation of information provided in response to this application.
- Neither the facility nor its managing employees, officers, directors, or major shareholders or owners (i.e. person with beneficial ownership of 5 percent or more) appear in Social Security Administration’s *Death Master File*; the *National Plan and Provider Enumeration System*; the *Medicare Exclusion Database*; the Michigan Department of Health and Human Services /Medical Services Administration, *Sanctioned Provider List*; the Licensing and Regulatory Affairs *Disciplinary Action Report*; and any other database as the secretary of HHS may prescribe. Nor has facility, its managing employees, offices, directors, partners, agents, or major shareholders or owners (i.e. person with beneficial ownership of 5% or more) been suspended, debarred or otherwise excluded under the Federal Acquisition Regulation as described in 42 CFR 438.610.
- There are no pending investigations, legal actions, or matters subject to arbitration involving facility or its managing employees, officers, directors, or major shareholders or owners (i.e. person with beneficial ownership of 5% or more) on matters relating to payments from governmental entities, both federal and state, for health care or prescription drug services. Additionally, neither facility nor its managing employees, officers, directors, major shareholders or owners (i.e. person with beneficial ownership of 5% or more) have been criminally convicted or have had a civil judgment entered against them for fraudulent activities.

*Print or type name	*Practitioner signature/title	*Date
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[Facility enrollment required document checklist](#)

Facility classification	To avoid processing delays, please ensure all items are submitted
Acute care hospital	<ul style="list-style-type: none"> • Copy of hospitals 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). • IRS document authorizing non-profit or tax-exempt status (if applicable) • Hospital organizational chart • Healthcare system's operating structure or organizational chart showing where the hospital falls within the organization (if applicable) • Copy of face Sheet or declaration sheet of current professional and general liability Insurance • Copy of most current accreditation certificates • 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 Michigan survey. • Most current Medicare provider number Letters (e.g., acute care, psych, rehab, ESRD) • Registration and certificate or inspection information for mammography, X-ray machines & all other ionizing equipment • CLIA certificate
Ambulatory infusion center	<ul style="list-style-type: none"> • Primary practice location in Michigan • Type 2 National Provider Identifier • Identified owner of Facility • Internal Revenue Service document identifying tax ID number and associated payee name
Ambulatory surgical facility	<ul style="list-style-type: none"> • Primary practice location in Michigan • Type 2 National Provider Identifier (NPI) • Identified owner of Facility • Internal Revenue Service document identifying tax ID number and associated payee name
Clinical independent laboratory	<ul style="list-style-type: none"> • Type 2 National Provider Identifier • Internal Revenue Service document identifying tax ID number and associated payee name
Durable medical equipment supplier	<ul style="list-style-type: none"> • Type 2 National Provider Identifier • Internal Revenue Service document identifying tax ID number and associated payee

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Facility classification	To avoid processing delays, please ensure all items are submitted
End stage renal disease	<ul style="list-style-type: none"> • Primary practice location in Michigan • Type 2 National Provider Identifier • Identified owner of Facility • Internal Revenue Service document identifying tax ID number and associated payee name
Federally qualified health center	<ul style="list-style-type: none"> • Medicare approval letter identifying address matching primary practice location and approval as Federally Qualified Health Center • Primary practice location in Michigan • Type 2 National Provider Identifier • Identified owner of facility • Internal Revenue Service document identifying tax ID number and associated payee name
Freestanding radiology center	<ul style="list-style-type: none"> • Primary practice location in Michigan • Type 2 National Provider Identifier • Identified owner of facility • Internal Revenue Service document identifying tax ID number and associated payee name
Home health care facility	<ul style="list-style-type: none"> • Type 2 National Provider Identifier (NPI) • Identified owner of facility • Internal Revenue Service document identifying tax ID number and associated payee name
Home infusion therapy	<ul style="list-style-type: none"> • Primary practice location in Michigan • Type 2 National Provider Identifier • Identified owner of facility • Internal Revenue Service document identifying tax ID number and associated payee name
Hospice	<ul style="list-style-type: none"> • Primary practice location in Michigan • Type 2 National Provider Identifier • Identified owner of Facility • Internal Revenue Service document identifying Tax ID number and associated payee name
Independent diagnostic testing facility	<ul style="list-style-type: none"> • Type 2 National Provider Identifier • Internal Revenue Service document identifying Tax ID number and associated payee name

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Facility classification	To avoid processing delays, please ensure all items are submitted
Long-term acute care hospital	<ul style="list-style-type: none"> • Primary practice location in Michigan • Type 2 National Provider Identifier • Identified owner of facility • Internal Revenue Service document identifying tax ID number and associated payee name • Must have a written transfer agreement with an acute care hospital
Outpatient Physical Therapy Facility	<ul style="list-style-type: none"> • Primary practice location in Michigan • Type 2 National Provider Identifier • Identified owner of facility • Internal Revenue Service document identifying tax ID number and associated payee name
Outpatient Psychiatric Center	<ul style="list-style-type: none"> • Primary practice location in Michigan • Type 2 National Provider Identifier • Identified owner of facility • Internal Revenue Service document identifying tax ID number and associated payee name
Prosthetic and Orthotic Suppliers	<ul style="list-style-type: none"> • Type 1 National Provider Identifier (for individually certified suppliers) • Type 2 National Provider Identifier (for organizationally certified suppliers) • Social security number (for individually certified suppliers) • Internal Revenue Service document identifying tax ID number and associated payee name
Rural Health Clinic	<ul style="list-style-type: none"> • Primary practice location in Michigan • Type 2 National Provider Identifier • Identified owner of facility • Internal Revenue Service document identifying tax ID number and associated payee name
Skilled Nursing Facility	<ul style="list-style-type: none"> • Primary practice location in Michigan • Type 2 National Provider Identifier • Identified owner of facility • Internal Revenue Service document identifying tax ID number and associated payee name
Urgent Care Center	<ul style="list-style-type: none"> • Type 2 National Provider Identifier • Internal Revenue Service document identifying tax ID number and associated payee name

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Credentialing – Healthcare professional and provider rights

Healthcare professional and providers have the right to:

- Review information obtained through primary source verification for credentialing purposes. This includes information from malpractice insurance carriers and state licensing boards. This does not include information collected from references, recommendations and other peer review protected information
- Be notified if any credential information is received that varies substantially from application information submitted by the health care professional or provider: (actions on license, malpractice claim history, suspension or termination of hospital privileges, or board-certification decisions with the exception of reference, recommendations or other peer-review protected information. The health care professional or provider will have the right to correct erroneous information if the credentialing information received varies substantially from the information that was submitted on his or her application
- Upon request, be informed of the status of their application – if application is current and complete, the applicant can be informed of the tentative date that his or her application will be presented to the Credentialing Committee for approval.