SKILLED NURSING FACILITY
APPLICATION

This application is used for the following networks/programs:
- Traditional
- Medicare Supplemental
- Medicare Advantage PPO

GENERAL INFORMATION

I. BCBSM's Skilled Nursing Facility Programs

Traditional

Participation in Blue Cross Blue Shield of Michigan’s (BCBSM) Traditional Skilled Nursing Facility (SNF) program is on a formal basis only. Services provided in a non-participating SNF are not reimbursed by BCBSM to either the facility or the member.

The attached application and required information applies to facilities that want to participate in BCBSM's network for members enrolled in our Traditional product. The SNF may be hospital-based or freestanding (non-hospital owned). BCBSM members who have the Convalescent and Long Term Care or SNF benefit are eligible to receive care at a participating skilled nursing facility. Please note, however, that members enrolled in non-Medicare BCBSM's PPO and Point of Service products (e.g., Community Blue PPO, Blue Preferred PPO, Blue Preferred Plus PPO, Blue Choice POS, etc.) use the BCBSM Traditional network unless a separate network for SNF services has been established for those members. Members of other Blue Cross Blue Shield (BCBS) Plans also use the Traditional network when receiving service in Michigan. Members must have a benefit for SNF care and must have SNF care days available. Services must meet the member's benefit criteria to be payable (e.g., preauthorization). Because not all BCBSM or BCBS members have coverage for SNF services, member benefits and eligibility should always be verified before providing services.

Medicare Advantage PPO

Facilities that are Medicare certified as Skilled Nursing Facilities are eligible to apply for affiliation in the BCBSM Medicare Advantage PPO network which became effective January 1, 2010. To be in the MA PPO network, SNFs do not need to be participating in the Traditional network but must meet all of the same requirements for Traditional participation.

Medicare Supplemental

Patients who have primary coverage through 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 additional days of care. In general, the effective date of a facility’s eligibility for payment under the BCBSM Medicare Supplemental program coincides with the effective date of the facility’s Medicare certification as a Skilled Nursing Facility. This date most likely will be different than the facility’s BCBSM Traditional or MA PPO program participation effective dates. All Skilled Nursing Facilities that are approved for participation in our Traditional program are approved for Medicare Supplemental payments. Medicare certified Skilled Nursing Facilities are eligible to obtain a BCBSM facility code for the billing of covered Medicare Supplemental
services even if the facility elects not to participate with BCBSM in our Traditional program. However, due to claims filing limitations, BCBSM will generally not assign a BCBSM Medicare Supplemental facility code with a retroactive effective date that exceeds a two year period.

II. BCBSM's Skilled Nursing Facility Qualification Requirements for Traditional and MA PPO

In order to participate with BCBSM a Skilled Nursing Facility must, at minimum, have and maintain the following:

- Licensure by the state of Michigan as a Nursing Home, Long Term Care facility, or as a Hospital Long Term Care Unit
- Medicare certification as a Skilled Nursing Facility
- Have an absence of inappropriate utilization or practice patterns as identified through valid subscriber complaints, medical necessity audits, peer review, and utilization management
- Have an absence of fraud and illegal activities
- Maintains adequate patient and financial records
- Cannot be a Medicare excluded entity

Note: It is BCBSM's policy to recredential participating providers every 2-3 years to verify continued compliance with all qualification requirements.

III. Skilled Nursing Facility Reimbursement

Participating SNFs are required to bill BCBSM for covered services and to accept BCBSM’s payment as payment in full for covered services, except for any applicable member copayments and/or deductibles.

A. Traditional Freestanding (non-hospital owned and operated) Skilled Nursing Facilities

For Freestanding Skilled Nursing Facilities, Reimbursement is made only for covered services provided by a Skilled Nursing Facility that is approved and contracted by BCBSM. Reimbursement is limited to the lesser of the facility’s billed charge or the BCBSM maximum payment level. The maximum payment level for freestanding Skilled Nursing Facilities is a per diem payment and varies according to geographic area.

If you obtained a copy of the application from our corporate website (bcbsm.com), you may contact us for a sample rate sheet. If/when the facility is approved for participation, the most current rate sheet will be sent with the participation agreement.

B. Traditional Hospital-Based (100% hospital owned and operated) Skilled Nursing Facilities

Reimbursement is made only for covered services provided by a Skilled Nursing Facility that is approved and contracted by BCBSM. The facility’s reimbursement is determined by the parent hospital's peer group assignment as defined in Exhibit B of the Participating Hospital Agreement (PHA).

- A Skilled Nursing Facility that is owned and operated by a peer group 1-4 or peer group 6-7 hospital, is reimbursed using the hospital-specific cost to charge ratio established in accordance with Exhibit B of the PHA.

A Skilled Nursing Facility that is owned and operated by a hospital that, for PHA purposes, is considered a peer group 5 hospital will be reimbursed at the same payment level established for the hospital's acute care services in accordance with Exhibit B of the PHA.
C. Medicare Advantage PPO (freestanding or hospital-based)

Reimbursement for SNFs that participate in the MA PPO network is made at the BCBSM Payment Rate(s) for the applicable service, less any applicable member copayments or deductibles. For the first year of the program (through December 31, 2010), the BCBSM Payment Rate for SNFs will be 100% of the facility’s CMS payment rate(s). Out-of-network providers are reimbursed at the CMS payment rate(s) but the member will be subject to additional out-of-network copayments and/or deductibles which must be collected from the member.

IV. The BCBSM Participation Agreements

The applicable Skilled Nursing Facility participation agreement(s) will be sent if/when the facility is approved for participation. If, however, the facility would like to review the agreements prior to submitting the application, you may request a sample copy from the BCBSM Provider Contracting department, or, the Traditional agreement is available as a link in the participation chapter of the provider manual on web-DENIS for those providers that already have web-DENIS access. The Traditional participation agreement is also on file with the Office of Financial and Insurance Regulation (OFIR). The payment rates and the terms and provisions of the Traditional and MA PPO agreements are not negotiable.

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 and members’ benefit plans will vary.
SKILLED NURSING FACILITY
BCBSM
APPLICATION INSTRUCTIONS

Please do not submit the application until the facility believes it meets all BCBSM qualification requirements and has all documents BCBSM requires (e.g., Medicare/CMS certification). Print (in ink) or type the information required in the space provided. If the application was retrieved from the provider enrollment section of the BCBSM website (bcbsm.com), you may print, complete and mail the application. Be certain that the application is complete and all required attachments are enclosed at the time of submission to BCBSM. Please do not put the application in a binder or use sheet protectors, folders or dividers.

If the Skilled Nursing Facility is already participating in BCBSM’s Traditional program but now wishes to participate in its MA PPO Program, please contact the person listed at the end of this section. An application may not be necessary.

Please mail (do not fax) the completed application, along with the required attachments to:

Patricia Helfrick, RN
Provider Contracting – 513E
Blue Cross Blue Shield of Michigan
600 E. Lafayette Blvd.
Detroit, MI 48226-2998

Contact the person listed at the end of this section if you do not receive a letter within two weeks from the date you sent the application. It takes approximately two weeks for us to review a complete application. Incomplete applications may be returned, delaying the review process.

After we review the application and accompanying documentation, we may contact the designated representative of the facility to set up an appointment for an on-site visit. The on-site visit includes a review of a sample of medical records to evaluate the applicant's compliance with BCBSM requirements, as outlined in this application. The facility must be ready for the on-site review at the time of submitting the application. If the facility is approved for Traditional and/or MA PPO program participation, the applicable participation agreement(s) will be offered. If the facility is not approved, we will send notification in writing indicating the reason(s) for the denial.

The facility may not submit claims and is not eligible for reimbursement unless and until the facility’s application for participation is approved by BCBSM and both parties sign the Skilled Nursing Facility Traditional participation agreement and/or the MA PPO participation agreement. If the facility is approved and offered one or both agreements, it will be asked to retain the agreements for its record and return the signed Signature Documents to BCBSM. The countersigned copy of the Signature Documents will be returned to the facility after the BCBSM Skilled Nursing Facility’s facility code has been activated for billing purposes, generally within three weeks of our receipt of the signed Signature Documents. For MA PPO, the effective date is the date indicated on the Signature Document. The effective date for participation in the BCBSM Traditional Skilled Nursing Facility program will be the date the application is approved by BCBSM. It is not retroactive to the date the application was sent or received. For facilities that are approved for the Medicare Supplemental program, the effective date for the facility’s eligibility for payment under the Medicare Supplemental program will generally coincide with the effective date of the facility’s Medicare certification as a Skilled Nursing Facility. Due to claims filing limitations, BCBSM will generally not assign a BCBSM Medicare Supplemental facility code with a retroactive effective date that exceeds a two year period. Facilities that are approved for the Medicare Supplemental-only program will receive a letter confirming their facility code assignment. If this application pertains to an ownership change and BCBSM approves an agreement effective date

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retroactive to the date of the ownership change, this is not in any way a guarantee that old claims will process. The facility is still subject to any applicable claims filing limitations.

A separate BCBSM facility code is assigned to each approved and 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’s internal identifier) for processing. Therefore, BCBSM recommends obtaining one NPI (in accordance with federal guidelines), for each location and provider type. Federal guidelines also allow for an NPI to be obtained for unique combinations of tax ID, location and taxonomy (specialty) codes. By choosing the same identification structure for your NPI numbers as your BCBSM provider codes, you will significantly improve our ability to accurately and promptly process your claims.

Upon completion of the application and contracting process, the facility will receive a welcome package with information on how to sign up for electronic billing and access to web-DENIS, BCBSM’s web-based information system for providers. Through web-DENIS the facility will have access to provider manuals, newsletters (e.g., The Record), and patient data such as contract eligibility and benefits. It is the facility’s responsibility to be familiar with and to adhere to all BCBCM billing and benefit requirements. It is also the responsibility of the facility to ensure its billing department (or billing agency) is compliant with all of BCBSM's billing requirements.

Participating SNFs must bill BCBSM on a UB-04 claim form or its electronic equivalent. BCBSM no longer accepts facility paper claims (with a few exceptions). Facilities that would like more information about internet claims submission or that wish to bill electronically should contact BCBSM's Electronic Data Input (EDI) Helpline at (800) 542-0945 for electronic billing information after their BCBM facility code has been received.

Facilities that participate in the Traditional or MA PPO networks or that are eligible to receive Medicare Supplemental payments from BCBSM must notify BCBSM immediately of any change in the facility’s ownership, tax identification number, CMS certification status, CMS certification number, NPI, address, telephone number, etc.

**Multiple Locations**

If the facility is applying for participation (or an ownership change) for more than one location, each location must meet all requirements in order to be approved. A separate BCBSM provider code is issued for each approved location and each approved location receives its own participation agreement. A separate application must be submitted for each location. Before completing the application, please make/print additional copies. The application for the first location must be completed in its entirety (with all attachments submitted). For each additional application submitted, complete the following sections: General Information (1.0), Medicare Certification (3.0), Licensure (4.0), and Staffing (5.0). For all other sections, indicate "same" where there is no difference. Where the information for a location is different than the first location, answer the questions and submit corresponding attachments. Before submitting the applications, please review all sections carefully to be sure appropriate information was completed for each location. If, however, you prefer to submit a "complete" application for each site, you may choose to do so.

Please direct any questions regarding completion of the application to:

Patricia Helfrick, RN  
Healthcare Analyst  
P/Helfrick@bcbsm.com

Telephone:  313-448-7896  
Fax:  866-393-8533
1.0 General Information

Indicate the type of application being submitted: (Check all that apply)

☐ The facility would like to formally participate in BCBSM’s Traditional Program and also bill BCBSM for covered Medicare Supplemental services.
☐ The facility would like to formally participate in BCBSM’s MA PPO Program, or
☐ The facility elects not to participate in BCBSM’s Traditional Program but wishes only to obtain a BCBSM facility code for the billing of covered Medicare Supplemental services. (Note: Facilities that make this election must complete this application, however, the only attachments the facility must submit are: the IRS documents (1.8), the facility’s Medicare certification (3.4 and 3.5) and the facility’s license (4.1).
☐ Ownership change involving a change in the facility’s federal Tax Identification Number. Please contact the person listed on the previous page regarding the ownership change before completing this application.

1.1 Business Name (This is the name the facility uses when doing business, or the DBA. It will be used for directories.)
_________________________________________________________________

1.2 Facility Site Address (for directory).
_________________________________________________________________
Suite Number _____ County ______
City _____________ State  MI  Zip Code _______________________________

1.3 Facility Telephone Number (for directory). (___) _________________________

1.4 Date facility began providing skilled nursing facility services to clients under the Tax ID indicated in 1.9. (MM/DD/YEAR).
_________________

1.5 Is the facility accepting new patients at this time?
☐ Yes
☐ No

1.6 Remittance address (This is the location where all BCBSM vouchers, checks and remittance advices should be sent.)
_________________________________________________________________
Suite number _______________  County____________________________
City ___________________________  State _____  Zip _______
1.7 Enter the facility’s 10 digit National Provider Identifier (NPI).
_____________________________________________

1.8 Tax Name (This is the name on file with the IRS and may be different from the facility’s business. name.)
_________________________________________________________________

1.9 Enter the facility’s federal tax identification number (TIN).
____________________________________________________

1.10 Attach a copy of Federal Tax Deposit Coupon (form-8109), or a copy of IRS notification letter (form SS4-147c), EFTPS (form–9787), or another document issued by the IRS with the facility’s federal tax identification number (TIN) on it.

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

1.12 If the facility is nonprofit, attach the IRS document authorizing tax exempt status.

1.13 Fiscal Year End (MM/DD/YEAR) ______________________________

1.14 Facility’s website (URL), if applicable __________________________

1.15 Place a check mark to indicate if the facility provides any of the following services.
☐ IV therapy
☐ Vent care

1.16 Does the facility accept patients that require dialysis?
☐ Yes
☐ No
If “Yes,” provide the dialysis provider’s name and the location where the services are rendered.
________________________________________________________________________

Note: The percentage of ownership for items 1.17 and 1.18 combined must equal 100%.

1.17 List the following information for the facility 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: ____________________________

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1.18 Provide the following information for the facility if an organization owns it or has managing control (e.g., hospital, corporation, governmental and/or tribal organizations, partnerships and limited partnerships, charitable and/or religious organizations, etc.)

<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>
</tbody>
</table>

1.19 If the facility is not 100% hospital owned and operated, skip to section 2.0.

1.20 If the facility is 100% hospital owned and operated, answer the remaining questions in this section.

1.20 a) Do the Skilled Nursing Facility and hospital identified above share the same tax identification number?

☐ Yes
☐ No

1.20 b) Is the Skilled Nursing Facility included in the hospital's organizational chart?

☐ Yes
☐ No

If "Yes," please submit a copy of the hospital's organizational chart and identify where the Skilled Nursing Facility falls within the chart.

1.20 c) Are the Skilled Nursing Facility’s policies and procedures included in the hospital’s policies and procedures?

☐ Yes
☐ No

1.20 d) Are the Skilled Nursing Facility’s utilization evaluation and or quality assurance plan(s) included in the hospital's Utilization Management/Quality Assurance plan?

☐ Yes
☐ No

1.20 e) Are the Skilled Nursing Facility's charges and costs included in the hospital's PHA cost report (as submitted to BCBSM)?

☐ Yes
☐ No

1.20f) Indicate the hospital’s BCBSM facility code ________________

2.0 **Administration**

2.1 **Attach a copy of the Skilled Nursing Facility's organizational chart.**

2.2 List the name and credentials of the facility's administrator:

Name ____________________________________________

Credentials (Degrees/Certificates, etc.) __________________________

2.3 Administrator's scheduled number of hours per week at facility ________________
2.4 **Attach a copy of the administrator's job description and qualifications.**

2.5 Has the facility or an officer, director, owner (e.g., individuals or parent organizations) or principal (those with significant authority and responsibility) of the facility 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:
____________________________________________________________________________
____________________________________________________________________________

2.6 Has the facility 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
____________________________________________________________________________
____________________________________________________________________________

3.0 **Medicare - Centers for Medicare and Medicaid Services (CMS)**

3.1 Provide the facility's Medicare certification number for skilled nursing services.
____________________________________________________________________________

Medicare effective date (MM/DD/YEAR) _____________________

3.2 Has the facility's license or Medicare number ever been revoked, suspended or terminated for skilled nursing services?

☐ Yes
☐ No

If "Yes," please explain:
____________________________________________________________________________
____________________________________________________________________________

3.3 Has the facility or any of its owners ever been excluded from state or federal programs?

☐ Yes
☐ No

If "Yes," please explain:
____________________________________________________________________________
____________________________________________________________________________

3.4 **Attach a copy of the letter issued by CMS that reflects the facility’s Medicare certification status. Note: the Medicare number indicated on the letter must match the number that was provided in 3.1.**
3.5 If the facility has had a Medicare recertification survey subsequent to the initial CMS certification, attach a copy of the most current state of Michigan survey report, or the follow-up letter (if applicable) that verifies the facility is in substantial compliance with all state and federal regulatory requirements.

3.6 If this application is being submitted due to a change of ownership, attach a copy of the CMS letter indicating authorization of the change of ownership.

4.0 Licensure

4.1 State the facility’s (i) Nursing Home, Long Term Care facility, or (ii) Hospital Long Term Care Unit license number, as issued by the state of Michigan, and its expiration date.

License # (permanent ID): _______________   Expiration Date: _______________

4.2 Attach a copy of the facility’s state of Michigan license as a (i) Nursing Home, Long Term Care facility, or (ii) Hospital Long Term Care Unit.

5.0 Staffing

5.1 Attach a copy of a current staff roster with credentials and job titles for the following professional/clinical staff: MD, DO, RN, LPN, PT, OT, SLP, social worker, nutritionist and physician extender.

5.2 Attach a copy of the current Michigan licenses or certifications for all professional/clinical staff listed in 5.1. Note – it is only necessary to provide copies of licenses for five RNs and five LPNs.

5.3 Indicate the name of the facility's nursing director

________________________________________________________________

5.4 Indicate the name of the physician medical director responsible for the direction of the medical care at the facility.

__________________________________________________________________________ □ MD □ DO

5.5 Medical director's specialty

__________________________________________________________________________

5.6 Indicate the facility medical director’s average number of scheduled hours per week at the facility (including both administrative and clinical duties).

__________________________________________________________________________
6.0 Medical Record Documentation

The medical record must contain documentation of the need for and the provision of all services rendered. All documentation must be clearly legible, signed, and dated.

BCBSM general requirements for medical record documentation include, but are not limited to:

- Patient identification information
- History
- Clinical findings
- Physician orders (certification of treatment)
- Results of diagnostic testing (if applicable)
- Diagnostic assessment
- Progress notes
- Treatment plan
- Periodic review of treatment plan
- Discharge summary

Additionally the BCBSM Skilled Nursing Facility program requires:

- The physician to write an assessment and treatment plan within 72 hours of a hospital transfer or within 24 hours of a direct admission (e.g., from home.) The hospital history and physical, discharge summary, and discharge orders do not fulfill this requirement unless the attending physician in the skilled nursing facility was also the attending physician in the hospital. If this is the case, and the hospital history and physical is used on admission to the Skilled Nursing Facility, then the admitting physician must sign the history and physical and must update it as necessary.

- Documentation of a progress note at a minimum frequency of at least once every two weeks. The physician’s progress notes should provide documentation of the medical necessity of continued skilled care and must include the following:
  - Interim history including reference to the patient’s response to therapy and current symptoms.
  - Clinical findings on re-examination
  - Interpretation of results of diagnostic tests
  - Diagnostic assessment
  - Changes in the therapy plan and rationale, including documentation of any treatment or procedure actually performed or prescribed.

6.1 Attach a copy of the facility’s policies and procedures for medical record documentation outlined in 6.0.

6.2 Attach a blank copy of all of the facility’s medical record forms.
7.0 **Utilization Management**

A utilization management system can result in improved member care and improved planning for more appropriate, effective, and efficient use of the facility's resources.

- The program must provide a written utilization evaluation system designed to review the appropriateness of admissions to the program, lengths of stay, discharge practices, use of services, quality, timeliness and completeness of member records, and any other factors that may contribute to the effective utilization of program resources.

- Utilization management must be administered by a multidisciplinary committee of staff who provide direct member services. The committee shall meet at least on a quarterly basis.

- Written utilization management findings and recommendations should be made available to administrative and treatment staff for study and appropriate action.

7.1 **Attach a copy of the facility's current utilization management policies and procedures.**

7.2 **Attach a copy of the names and credentials (i.e., MD, DO, RN, PT, etc.) of the Utilization Management Committee's members.**

7.3 **Attach minutes from the last two quarterly Utilization Management Committee meetings.**

8.0 **Financial and Billing Information**

8.1 Does the facility maintain records of transactions that conform to generally accepted accounting principles?

- Yes
- No

8.2 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 below:

_________________________________________________________________

8.3 In the past five years, has the facility 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 facility's assets?

- Yes
- No

If "Yes," provide an explanation below:

_________________________________________________________________
8.4 Does the facility use a billing department or billing agency that is located outside of Michigan?
- ☐ Yes
- ☐ No

If “Yes,” please indicate the contact person, company name, address, telephone number, (and e-mail address if available) for the company or billing agency that is responsible for submitting claims for services provided at the facility.

Contact person

Company name

Mailing address

City __________________________ State ______ Zip Code __________

Telephone number                  

E-mail address

9.0 Management Contracts

9.1 Does the facility 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.

______________________________________________________________________

10.0 Contact Person

10.1 Please give the following information for a contact person for any questions BCBSM may have regarding this application:

Name: _________________________________

Title: _________________________________

Mailing Address: _______________________________

Telephone number: _______________________________

E-mail address: _______________________________
11.0 **Signature and Attestation**

I certify by my signature below that:

- I have reviewed the information in this application and to the best of my knowledge it is a complete and accurate representation of this facility's operations.
- I understand that BCBSM may choose to do an on-site survey after review of this application to verify program compliance and to verify the accuracy of any information provided.
- Facility's Medicare certification as a skilled nursing facility is current and valid.
- Facility is not currently an excluded entity by Medicare and does not employ individuals who are Medicare excluded individuals.
- All licenses for professional providers who provide direct patient care for this facility are current and valid in Michigan.
- Facility’s Michigan license as a Nursing Home, Long Term Care Facility; or as a Hospital Long Term Care Unit is current and valid.
- The enclosed policies and procedures have been implemented and are enforced by this facility.
- The facility maintains financial records that conform to generally accepted accounting principles and practices.
- I understand the effective date of Traditional participation, if approved, is the date the application is actually approved by BCBSM, and for MA PPO, the date indicated on the Signature document, and is not the date the application was sent or received.
- For the Traditional Program, I understand the facility is not eligible to submit claims for payment under any programs until it is approved by BCBSM, both parties sign the participating agreements, BCBSM claims processing systems are activated, and the facility has received a copy of the countersigned Signature Documents from BCBSM.
- I understand and agree that if the facility has elected not to participate in BCBSM's Traditional SNF Program and that if BCBSM assigns a SNF facility code that is only for Medicare Supplemental payments, that BCBSM has the right to audit the facility's patient records to verify that all services billed and paid are benefits and that covered services billed and paid were delivered and documented. I understand and agree that BCBSM will have the right to recover any monies paid for services paid in error, that were not benefits (i.e., not covered services) or that were not appropriately documented in facility's medical records.
- I understand BCBSM's payment rates and the terms of its standard participation agreement are not negotiable.

**Note:** This application must be signed by the person at the facility who is responsible for the overall administration of the skilled nursing facility program.

**Authorized facility representative**

By:  
(surname-required)

Name:  
(print or type)

Title:  
(print or type)

Date:  
(print or type)
Checklist for Skilled Nursing Facility Application Attachments

- Federal Tax Deposit Coupon (form-8109), copy of the facility's IRS notification letter (form SS4-147c), or EFTPS (form-9787)
- IRS document authorizing tax exempt status (if applicable)
- hospital's organizational chart showing the skilled nursing facility in the hospital's organizational structure (if applicable)
- facility's organizational chart
- facility administrator's job description and qualifications
- proof of Medicare certification as a Skilled Nursing Facility (including Medicare number)
- copy of the Medicare letter designating the SNF as provider-based, if applicable
- If the facility has had a Medicare recertification survey subsequent to the initial CMS certification, attach a copy of the most current state of Michigan survey report, or the follow-up letter (if applicable) that verifies the facility is in substantial compliance with all state and federal regulatory requirements.
- copy of Medicare letter authorizing change of ownership (if applicable)
- proof of facility's Michigan license as a Nursing Home, Long Term Care facility, or as a Hospital Long Term Care Unit
- facility's current staff roster, with credentials, job titles, and full time equivalents
- current licenses for all professional/clinical staff (including medical director and nursing director)
  Note – it is only necessary to provide copies of licenses for five RNs and five LPNs.
- facility's policies and procedures pertaining to medical record documentation of skilled nursing services
- facility’s medical record forms
- facility's current utilization management policy and procedure
- attestation statement signed by an authorized facility representative

Return completed application with all the attachments to:

    Patricia Helfrick, RN  
    Provider Contracting - Mail Code 513E  
    Blue Cross Blue Shield of Michigan  
    600 E. Lafayette Blvd.  
    Detroit, MI 48226-2998