HOSPICE FACILITY
APPLICATION FOR BCBSM PARTICIPATION FOR THE
TRADITIONAL PROGRAM

GENERAL INFORMATION

I. BCBSM’s Hospice Program

The BCBSM Hospice program provides benefits for eligible members for medical, psychological, social and spiritual services for terminally ill patients and their families. Hospice care primarily focuses on the reduction of the physical and psychological symptoms of a patient diagnosed with a terminally ill disease. Certification of a terminal diagnosis must be signed by the patient's attending physician. Hospice care focuses on providing treatment that reduces or relieves the physical and psychological symptoms of a patient's terminal disease, rather than actively seeking a cure. This type of care is also referred to as palliative treatment.

Traditional

Participation with Blue Cross Blue Shield of Michigan’s (BCBSM) Traditional program is on a formal basis only for all hospice facilities (whether hospital owned or not). Services provided in a non-participating Hospice 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. Please note, however, that members enrolled in 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 hospice services has been established for those members. Members of other Blue Cross Blue Shield (BCBS) Plans also use the Traditional network. Be sure to verify benefit and eligibility for all BCBSM or BCBS members before providing services.

Medicare Supplemental

Patients who have primary coverage through Medicare may also have Medicare Supplemental coverage through BCBSM for nursing home care with hospice support (fifth level of care)The effective date of a facility's eligibility to receive payment for the BCBSM Medicare Supplemental program coincides with its Traditional program effective date.

II. BCBSM's Hospice Qualification Requirements

In order to participate with BCBSM a Hospice program must, at minimum, have and maintain the following:

- Current Medicare certification as a hospice agency
- Licensure as a hospice by the state of Michigan
- Membership in either:
  - The National Hospice and Palliative Care Organization, or
  - The Michigan Hospice and Palliative Care Organization
- A multi-disciplinary staff composed of the following:
a Michigan licensed physician medical director to provide overall direction for the clinical aspect of hospice services

- registered nurses who provide or supervise the nursing care requirements of patients
- a licensed social worker
- a pastoral or bereavement counselor.
- a volunteer staff sufficient to provide administrative or direct patient care equaling at least five percent of total patient hours of patient care provided by all paid employees and contract staff

- In addition, the facility must have and maintain the following general requirements that include:
  - facility must provide the following services: physical therapy, occupational therapy, speech and language therapy, home health aide, medical supplies/equipment, drugs and biologicals, and short term inpatient care
  - facility has written policies and procedures that meet generally acceptable standards for hospice services to assure the quality of patient care, and facility demonstrates compliance with such policies and procedures
  - facility maintains a ratio of at least 80 percent home care days and no more than 20 percent inpatient days for BCBSM members
  - facility can demonstrate that it conducts program evaluation and utilization review to assess the appropriateness, adequacy and effectiveness of the program's administrative and clinical components
  - facility meets BCBSM's Evidence of Necessity (EON) requirements, if applicable
  - facility has a governing board that is legally responsible for the total operation of facility. The governing board, or as an alternative, a community advisory board responsible to the governing board, shall include persons representative of a cross section of the community who are interested in the welfare and proper functioning of facility as a community agency.
  - facility has an absence of inappropriate utilization or practice patterns, as identified through valid subscriber complaints, audits and peer review
  - facility has an absence of fraud and illegal activities
  - facility maintains adequate patient and financial records

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

III. Levels of Care

A Hospice facility is responsible for providing and coordinating all services to treat a patient's terminal illness, and related conditions, including appliances, durable medical equipment, medical supplies, radiology, lab and drugs. The facility must be able to provide either directly, or through contractual arrangements, routine home care, continuous home care, inpatient respite care, and general inpatient care as described below.

1) Routine Home Care
   Routine home care consists of services provided to patients who are living at home and are not receiving continuous home care, as described below. Routine home care includes such services as nursing, counseling, home health aide and physical therapy. Routine home care is provided less than eight continuous hours per day.

2) Continuous Home Care
   Nursing care provided to hospice patients during crisis periods to enable patients to stay in their home. Continuous home care is provided eight or more hours per day.

3) Inpatient Respite Care
Inpatient respite care consists of short-term inpatient services provided to allow the patient’s home-care providers short periods of relief. Care must be:
- provided on a non-routine and occasional basis
- provided in increments of five days or less during any 30-day period
- provided by the hospice facility’s own inpatient unit (that meets Medicare’s standards for inpatient care), or by one of the BCBSM participating facilities below:
  - a hospital that contracts with the hospice
  - a Skilled Nursing Facility (SNF) that contracts with the hospice

4) General Inpatient Care
General inpatient care consists of inpatient services provided for pain control, or acute or chronic symptom management that cannot be provided in other less intensive settings. General inpatient care must be provided by the hospice facility’s own inpatient unit (that meets Medicare’s standards for inpatient care) or by one of the following types of BCBSM participating facilities:
- a hospital that contracts with the hospice
- a Skilled Nursing Facility (SNF) that contracts with the hospice

5) Nursing Home Care with Hospice Support*
Nursing Home Care with Hospice Support consists of care provided in a nursing home to patients who are medically stable but unable to return home because of their need for assistance and the unavailability of a primary care provider. Nursing home care with hospice support must be provided by one of the hospice facility’s own inpatient units (that meets Medicare’s standards for inpatient care) or by one of the following facilities:
- a BCBSM participating hospital that contracts with the patient’s specified hospice
- a licensed and Medicare certified Skilled Nursing Facility (SNF) that contracts with the patient’s specified hospice

*Nursing home care with hospice support is a level of hospice care that is a benefit only for certain customer groups, however, it is not required to be provided by all BCBSM participating hospice facilities.

IV. Hospice (Freestanding and Hospital-based) Facility Reimbursement

There are for five levels of care listed on the BCBSM Hospice Provider Rate Schedule (Rate Schedule). Each level of care on the Rate Schedule has an assigned all-inclusive maximum payment rate. BCBSM will reimburse Facility the lesser of billed charges or the maximum payment rate on the Rate Schedule. The Rate Schedule for each primary location will vary depending on the Medicare defined geographic area the facility is located in. BCBSM will reimburse Facility according to the Rate Schedule in effect on the date the Covered Service was provided.

In addition, Facility is reimbursed a separate fee for direct care visits provided by physicians employed by or under contract with Facility. The fee is limited to the lesser of Facility’s billed charge or the BCBSM (physician) Traditional Product Maximum Payment Schedule that is in effect on the date of service. Covered Services provided by physicians who are not employed by or under contract with Facility are separately reimbursable to such physicians.

Participating Hospice providers are required to bill BCBSM for all covered hospice services and to accept BCBSM’s payment as payment in full for covered services, except for any member copayments and/or deductibles. BCBSM will reimburse the facility for covered services provided at its primary location and all Medicare and BCBSM approved branch locations according to the
BCBSM Rate Schedule applicable to its primary location. The Rate Schedule is BCBSM’s standard rate schedule and is not negotiable. If you obtained a copy of the application from our corporate website (bcbsm.com), you may contact the BCBSM Provider Contracting department for a sample rate sheet. If/when the facility is approved for participation, the most current Rate Schedule will be sent with the participation agreement.

V. The BCBSM Participation Agreement

The Hospice facility participation agreement will be sent if/when the facility is approved for participation. If, however, the facility would like to review the agreement prior to submitting the application, you may request a sample copy from BCBSM. The participation agreement is on file with the Office of Financial and Insurance Services and its terms and provisions 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.
HOSPICE PROGRAM
BCBSM TRADITIONAL
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.

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

Patricia K. 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 program participation, the participation agreement 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 Hospice participation agreement. If the facility is approved and offered a Traditional participation agreement, it will be asked to retain the agreement for its record and return the signed Signature Document to BCBSM. The countersigned copy of the Signature Document will be returned to the facility after the BCBSM Hospice facility’s facility code has been activated for billing purposes, generally within three weeks of our receipt of the signed Signature Document. The effective date for participation in the BCBSM Traditional Hospice program will be the date the application is approved by BCBSM. It is not retroactive to the date the application was sent or received. If this application pertains to an ownership change and BCBSM approves an agreement effective date 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 primary location. Approved branch locations use the same facility code as the primary location when submitting claims to BCBSM. With the implementation of NPI in 2007, BCBSM will crosswalk the claims from the facility’s NPI to the BCBSM (primary) 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 reduce the degree of change required to adopt NPI and allow us to process your claims without manual intervention (which could cause potential delays).

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 hospice facilities must bill BCBSM on a UB-92 claim form or its electronic equivalent. BCBSM will no longer accept facility paper claims (with some exceptions) by late 2006 or early 2007. Facilities that would like more information about internet claims submission or who 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 program must notify BCBSM *immediately* of any change in the facility’s ownership, tax identification number, CMS certification number, addition/deletion of branch locations, NPI, address, telephone number, etc.

**Multiple Locations**

If the facility is applying for participation (or an ownership change), a separate application must be completed for each primary location. If the facility has multiple branch locations (extensions), please list them in the appropriate section of this application. Each site must meet all qualification standards in order to be approved. A separate BCBSM provider code is issued for each approved primary location and each approved primary location receives its own participation agreement. This same facility code should also be used when billing for services provided at the facility’s approved branch locations. Before completing the application, please make/print additional copies. The application for the first primary location must be completed in its entirety (with all attachments submitted). For each additional primary location application submitted, complete the following sections: General Information (1.0), Licensure (4.0), Medicare Certification (6.0), and Staffing (7.0). 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 K. Helfrick, RN  
Qualifications Consultant  
phelfrick@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

☐ 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 Primary Site Address (for directory)

___________________________________________________________

Suite Number _________ County _________________
City _________________________ State MI Zip code ________

1.3 Facility Telephone Number (for directory) (___) __________________

1.4 Business hours

___________________________________________________________

1.5 Date facility began servicing hospice patients under the Tax ID indicated in Section 1.10 (MM/DD/Year) ____________

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

1.7 Remittance Address (This is the location where all BCBSM vouchers, checks and remittance advices should be sent)

___________________________________________________________

Suite Number _________ County _________________
City _________________________ State ___________ Zip code ______________

1.8 Enter the facility’s 10 digit National Provider Identifier (NPI).

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

______________________________________________________________________________

1.10 Enter the facility’s federal tax identification number (TIN)

______________________________________________________________________________

1.11 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.

1.12 Check applicable field:
☐ For Profit
☐ Nonprofit/Tax Exempt

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

1.14 Fiscal year End (MM/DD/YEAR) _______

1.15 Facility’s website (URL), if applicable ________________

Note: The percentage of ownership for items 1.16 and 1.17 combined must equal 100%.

1.16 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: ______________________________

1.17 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.)

Organization’s name
Percent ownership (if applicable)

______________________________________________________________________________ Ownership ___

______________________________________________________________________________ Ownership ___

1.18 If the facility is not 100% hospital owned and operated, please skip to section 2.0.
1.19 If the facility is 100% hospital owned and operated, answer the remaining questions in this section.

1.19(a) Do the Hospice facility and hospital identified above share the same tax identification number?
   □ Yes
   □ No

1.19(b) Is the Hospice 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 Hospice facility falls within the chart.

1.19(c) Are the Hospice facility's policies and procedures included in the hospital's policies and procedures?
   □ Yes
   □ No

1.19(d) Are the Hospice facility's utilization evaluation and or quality assurance plan(s) included in the hospital's Utilization Management/Quality Assurance plan?
   □ Yes
   □ No

1.19(e) Indicate the hospital’s BCBSM facility code _______________

2.0 Administration

2.1 Attach a copy of the Hospice facility's organizational chart.

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

   Name ____________________________________________

   Credentials (Degrees/Certifications) ____________________

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 Governing or Advisory Board

3.1 Does the facility 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 facility and for ensuring that quality care is provided in a safe environment?
☐ Yes
☐ No

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

3.3 Attach a list of the name, city and state of residence, and occupation of all members of the governing or advisory board.

3.4 Attach a copy of the policies and procedures that outline the functions and responsibilities of the board.

4.0 Licensure

4.1 State the facility’s Hospice license number, as issued by the state of Michigan.
____________________________________________

4.2 Attach a copy of the facility’s state of Michigan Hospice license.

5.0 Professional Organization Membership(s)

5.1 Indicate below the professional organization(s) in which the facility has current membership.
☐ The National Hospice and Palliative Care Organization
☐ The Michigan Hospice and Palliative Care Organization

5.2 Attach a copy of a current letter or certification verifying the above membership.
6.0 Medicare – Centers for Medicare and Medicaid Services (CMS)

6.1 Provide the facility’s Medicare certification number for hospice services.

___________________________________________

Medicare effective date (MM/DD/YEAR)___________________

6.2 List each CMS approved branch/extension location(s) to be reviewed as part of this application

Branch #1 address _____________________________________

Telephone number ___________________County_____________

Medicare effective date __________________________________

Branch #2 address _____________________________________

Telephone number ___________________County_____________

Medicare effective date __________________________________

The information required in 6.2 should be taken directly from the CMS approval letter(s)

Note: If the facility has additional branch locations, attach a list with the above information.

6.3 Attach a copy of the letter(s) issued by CMS that reflect the facility’s Medicare certification status. Note: The Medicare number indicated on the letters must match the number that was provided in 6.1.

6.4 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, JCAHO or CHAP deemed status survey report, or the follow-up letter (if applicable) that verifies the facility is in substantial compliance with all state and federal regulatory requirements.

6.5 Has the facility's license or Medicare number ever been revoked, suspended or terminated for hospice services?

☐ Yes
☐ No

If "Yes," please explain:

________________________________________________________________________
________________________________________________________________________

Revised: July 2011
6.6 Has the facility or any of its owners ever been excluded from state or federal programs?
☐ Yes
☐ No
If "Yes," please explain:
________________________________________________________________________
________________________________________________________________________

6.7 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.

7.0 Staffing

7.1 Name of facility's physician medical director
__________________________________ ☐ MD ☐ DO

7.2 Physician medical director's specialty
__________________________________

7.3 Indicate below whether the physician medical director is board certified or board eligible in
the above specialty.
☐ Board Certified
☐ Board Eligible

7.4 Attach a copy of the physician medical director's board certification(s) or proof of
board eligibility.

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

7.6 Attach copy of a current staff roster with credentials (e.g., MD, DO, RN, etc.) and job
titles for all professional/clinical staff (including physicians).

7.7 Attach a copy of the current Michigan licenses for all professional/clinical staff listed
in 7.6.
8.0 **Levels of Care**

8.1 Place a checkmark below in the appropriate boxes to indicate which levels of care the facility provides and whether each level of care, where applicable, is provided directly by the facility or by contracted facilities/staff. (More than one box may be checked if the care is provided both directly and on a contracted basis).

1) Routine home care
   - □ Directly provided
   - □ Contracted
   - □ Not Provided

2) Continuous home care
   - □ Directly provided
   - □ Contracted
   - □ Not Provided

3) Inpatient respite care
   - □ Directly provided
   - □ Contracted
   - □ Not Provided

4) General inpatient care
   - □ Directly provided
   - □ Contracted
   - □ Not Provided

5) Nursing home care with hospice support
   - □ Directly provided
   - □ Contracted
   - □ Not Provided

8.2 If you indicated in 8.1 that one or more levels of care are not directly provided by your facility, attach a copy of a contract you have in place for at least one of the contracted facilities for each level of care where this is applicable.

9.0 **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 finding
- 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 Hospice program requires the following information:

- documentation that supports the type of care provided the patient and family members throughout the entire stages of treatment including: routine home care, continuous home care, inpatient respite care and general inpatient care
- terminal diagnosis as certified by a physician, and a medical prognosis that indicates a life expectancy of six months or less
- election statement consenting to hospice care
- cancellation statement, if patient decides to cancel hospice care
- re-election statement, if patient decides to re-elect hospice care

9.1 Attach a copy of the facility's policies and procedures for each medical record documentation requirement outlined in 9.0.

9.2 Attach a blank copy of all of the facility’s medical record forms.

9.3 Attach a copy of the facility's following statements for:
- hospice care election
- canceling hospice care, and
- re-electing hospice care

10.0 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.

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

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

10.3 Attach minutes from the last two quarterly Utilization Management Committee meetings.
## 11.0 Service Area

Please refer to the Michigan county listing below and indicate the counties the facility provides services to.

| ___ALCONA  | ___DICKINSON  | ___LAKE  | ___OCEANA  |
| ___ALGER   | ___EATON     | ___LAPEER| ___OGEMAW  |
| ___ALLEGAN | ___EMMET    | ___LEELANAU| ___ONTONAGON|
| ___ALPENA  | ___GENESEE  | ___LENAWEE| ___OSCEOLA |
| ___ANTRIM  | ___GLADWIN  | ___LIVINGSTON| ___OSCODA |
| ___ARENAC  | ___GOGEBIC  | ___LUCE  | ___OTSEGO  |
| ___BARAGA  | ___GRAND TRAVERSE| ___MACKINAC| ___OTTAWA |
| ___BARRY   | ___GRATIOT  | ___MACOMB| ___PRESQUE ISLE |
| ___BAY     | ___HILLSDALE| ___MANISTEE| ___ROSCOMMON |
| ___BENZIE  | ___HOUGHTON | ___MARQUETTE| ___SAGINAW |
| ___BERRIEN | ___HURON    | ___MASON  | ___SAINT CLAIR |
| ___BRANCH  | ___INGHAM   | ___MECOSTA| ___SAINT JOSEPH |
| ___CALHOUN | ___IONIA    | ___MENOMINEE| ___SANILAC |
| ___CASS    | ___IOSCO    | ___MIDLAND| ___SCHOOLCRAFT |
| ___CHARLEVOIX| ___IRON    | ___MISSAUKEE| ___SHIAWASEE |
| ___CHEBOYGAN| ___ISABELLA | ___MONROE | ___TUSCOLA |
| ___CHIPPEWA| ___JACKSON  | ___MONTCALM| ___VAN BUREN |
| ___CLARE   | ___KALAMAZOO| ___MONTMORENCY| ___WASHTENAW |
| ___CLINTON | ___KALKASKA | ___MUSKEGON| ___WAYNE |
| ___CRAWFORD| ___KENT     | ___NEWAYGO| ___WEXFORD |
| ___DELTA   | ___KEWEENAW | ___OAKLAND |
12.0 Financial and Billing Information

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

12.2 Does the facility maintain documentation to support services billed?
☐ Yes
☐ No

12.3 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:
________________________________________________________________________
________________________________________________________________________

12.4 Does the facility use a billing agency that is located outside of Michigan?
☐ Yes
☐ No

If "Yes," please indicate the contact person, company name, mailing 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

12.5 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:
________________________________________________________________________
13.0 **Management Contracts**

13.1 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.

______________________________________________________________________
______________________________________________________________________

14.0 **Contact Person**

14.1 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: ______________________________________________
15.0 **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.
- All licenses for professional providers who provide direct patient care for this facility are current and valid in Michigan.
- Facility's Medicare certification as a hospice agency is current and valid.
- Facility’s Michigan license as a Hospice facility 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 participation, if approved, is the date the application is actually approved by BCBSM 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 this program until it is approved by BCBSM, both parties sign the participating agreement, BCBSM claims processing systems are activated, and the facility has received a copy of the countersigned Signature Document from BCBSM.
- 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 who is responsible for the overall administration of the facility's hospice care program.

**Authorized facility representative**

By  

X  

(signature - required)

Name  

(print or type)

Title  

(print or type)

Date  


Return completed application with all the attachments to:

Patricia K. Helfrick, RN  
Provider Contracting – 513E  
Blue Cross Blue Shield of Michigan  
600 E. Lafayette Blvd.  
Detroit, MI 48226-2998
Checklist for Hospice Program
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)
- facility’s organizational chart
- facility's administrator's job description and qualifications
- facility's governing/advisory board members, meeting minutes, policy and procedures outlining the functions and responsibilities of the board
- evidence the facility's governing/advisory board includes community representation
- facility's State of Michigan license as a hospice
- proof of membership in one of the professional hospice organizations listed in this application
- proof of Medicare certification as a hospice agency (if multiple sites attach proof of certification for each site)
- 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, JCAHO or CHAP deemed status 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 the Medicare letter authorizing change of ownership (if applicable)
- proof of medical director’s current physician licensure in the state of Michigan and (where applicable) board certification or eligibility
- facility's current staff roster, credentials and job titles
- current Michigan licenses for all professional/clinical staff
- contracts for all levels of care not directly provided by the facility
- facility’s policies and procedures pertaining to medical record documentation of hospice services
- facility’s medical record forms
- sample of facility's hospice election statement
- sample of facility’s hospice cancellation statement
- sample of facility's hospice re-election statement
- facility’s utilization management policies and procedures
- attestation statement signed by an authorized facility representative