



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

## FACILITY PROVIDER RECREDENTIALING

	Type 2 National provider identifier	Tax Identification Number
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### Section 1: Demographic Data

\*denotes a required field

*Provider Name	
*What type of Facility are you? (select 1 per application)	
<ul style="list-style-type: none"> <li>Acute Care Hospital</li> <li>Ambulatory Infusion Center</li> <li>Ambulatory Surgery Facility</li> <li>Critical Access Hospital</li> <li>End-Stage Renal Disease</li> <li>Federally Qualified Health Center</li> <li>Halfway House</li> <li>Home Health Care</li> <li>Home Infusion Therapy</li> <li>Hospice</li> </ul>	<ul style="list-style-type: none"> <li>Long-Term Hospital</li> <li>Outpatient Physical Therapy Facility</li> <li>Outpatient Psychiatric Care Facility</li> <li>Psychiatric Hospital</li> <li>Psychiatric Residential Treatment Facility</li> <li>Rehabilitation Hospital</li> <li>Rural Health Clinic</li> <li>Skilled Nursing Facility</li> <li>Substance Abuse Facility</li> </ul>

### Substance Abuse Specialty and Services Data

Facility type Substance Abuse must indicate specialties and services provided, by checking the appropriate box(es) below.

Servicing Questions by Facility Type:

<b>Substance Abuse Facility</b>			
Check the box to identify the type of programs offered. Appropriate Michigan licensure is required for all programs/services provided:			
Outpatient	Residential/Inpatient (Is Registered Nurse personnel on-site on a 24 hr basis)?	Yes	No
Methadone (also requires proof of DEA license to be attached)			

### Section 2: Professional ID/Required Documents/Accreditations/Organizations

Please attach applicable documents with this application form \* Required

Provider Classification	Required Accreditations and CMS/Medicare documents
<ul style="list-style-type: none"> <li>• Ambulatory Surgery Facility</li> </ul>	<ul style="list-style-type: none"> <li>AAAHC - Accreditation Association for Ambulatory Health Care</li> <li>AAAASF - American Association for the Accreditation of Ambulatory Surgery Facilities</li> <li>HFAP - Healthcare Facilities Accreditation Program</li> <li>TJC - The Joint Commission</li> <li>CMS Survey or a copy of the CMS letter indicating the facility is in substantial compliance with state and federal regulations</li> </ul>



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### Section 2: Professional ID/Required Documents/Accreditations/Organizations continued

<ul style="list-style-type: none"> <li>• Ambulatory Infusion Center</li> </ul>	ACHC - Accreditation Commission for Health Care CHAP - Community Health Accreditation Program TJC - The Joint Commission
<ul style="list-style-type: none"> <li>• Halfway House</li> <li>• Outpatient Psychiatric Care Facility</li> <li>• Substance Abuse Facility</li> </ul>	AAAHC - Accreditation Association for Ambulatory Health Care COA- Council on Accreditation of Services for Families and Children CARF- Commission on Accreditation of Rehabilitation Facilities HFAP- Healthcare Facilities Accreditation Program TJC- The Joint Commission
<ul style="list-style-type: none"> <li>• Home Health Care Facility</li> <li>• Skilled Nursing Facility</li> <li>• End Stage Renal Disease Facility</li> <li>• Federally Qualified Health Centers</li> <li>• Rural Health Clinic</li> </ul>	AAAASF - American Association for the Accreditation of Ambulatory Surgery Facilities ACHC - Accreditation Commission for Health Care CARF - Commission on Accreditation of Rehabilitation Facilities CHAP -Community Health Accreditation Program HRSA - Health Resources and Services Administration TJC - The Joint Commission CMS Survey or a copy of the CMS letter indicating the facility is in substantial compliance with state and federal regulations
<ul style="list-style-type: none"> <li>• Home Infusion Therapy</li> </ul>	ACHC - Accreditation Commission for Health Care CHAP - Community Health Accreditation Program TJC - The Joint Commission CMS Survey or a copy of the CMS letter indicating the facility is in substantial compliance with state and federal regulations
<ul style="list-style-type: none"> <li>• Hospice</li> </ul>	ACHC - Accreditation Commission for Health Care CHAP - Community Health Accreditation Program HFAP- Healthcare Facilities Accreditation Program TJC- The Joint Commission CMS Survey or a copy of the CMS letter indicating the facility is in substantial compliance with state and federal regulations
<ul style="list-style-type: none"> <li>• Acute Care Hospital</li> <li>• Critical Access Hospital</li> <li>• Long-Term Hospital</li> <li>• Psychiatric Hospital</li> <li>• Rehabilitation Hospital</li> </ul>	AAAHC - Accreditation Association for Ambulatory Health Care CARF - Commission on Accreditation of Rehabilitation Facilities COA - Council on Accreditation of Services for Families and Children DNV - Det Norske Veritas GL Healthcare Inc HFAP - Healthcare Facilities Accreditation Program TJC - The Joint Commission CMS Survey or a copy of the CMS letter indicating the facility is in substantial compliance with state and federal regulations
<ul style="list-style-type: none"> <li>• Outpatient Physical Therapy</li> </ul>	AAAASF - Association for the Accreditation of Ambulatory Surgery Facilities CARF - Commission on Accreditation of Rehabilitation Facilities CHAP - Community Health Accreditation Program HFAP - Healthcare Facilities Accreditation Program TJC- The Joint Commission CMS Survey or a copy of the CMS letter indicating the facility is in substantial compliance with state and federal regulations

CMS Certification #:	State of Michigan license #:
State Partial Hospitalization Psychiatric license #:	
Medicaid #:	









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### Section 4: Facility Ownership

<b>Additional Ownership Questions</b>	
Is facility 100% hospital owned?    Yes    No	
If Yes, please provide hospital name: _____	
Hospital address: _____	
Does the facility and hospital share the same tax ID?    Yes    No	
Is your facility recognized by CMS as provider-based?    Yes    No	
<b>Staffing *Required</b>	
Are the medical staff credentialed through an:    Internal Process    Outside Agency.	
If an Outside Agency is used, please provide the Agency's Name: _____	
Medical Director name	Michigan license number
Medical Director credentials (MD, DO, Specialty)	Medical Director Type 1 NPI

### Section 4: Facility Ownership and Staffing continued

<b>General</b>
Has the facility or an officer, director, or owner ever had any convictions, guilty pleas, civil judgments or actions related to the provision or payment of health care?    Yes    No
Has the facility or its owner ever been subject to a corporate integrity agreement or found to have been non-compliant with self-dealing or anti-kickback laws?    Yes    No
Has the facility or its owner ever been excluded from State or Federal/CMS programs?    Yes    No
Has the facility or any of its owners filed for relief under the US Bankruptcy Code or taken any action to dissolve, terminate, consolidate, merge, or sell all of its assets?    Yes    No
Has the facility's Medicare number/certification ever been revoked, suspended, or terminated?    Yes    No

### Section 5: Application Attachments/Checklist

<b>Application Attachments/Checklist</b>
<ul style="list-style-type: none"> <li>___ Copy of Facility License</li> <li>___ Copy of current Professional and General Liability Insurance</li> <li>___ Copy of Accreditation Certificate and/or Accreditation Approval Letter</li> <li>___ Clinical Laboratory Improvement Amendments (CLIA) Certificate</li> <li>___ If not accredited, most recent copy of CMS recertification survey or a copy of the CMS letter showing substantial compliance for applicable facilities</li> <li>___ Copy of CMS Medicare Certification Letter for applicable facilities</li> <li>___ Certificate of Need (CON) required for PE Scanners, MRI, and Megavoltage Radiation Therapy</li> <li>___ Registration and certificate/inspection information for mammography, x-ray machines &amp; all other ionizing equipment</li> <li>___ Copy of DEA license (for Substance Abuse facility licensed for Methadone)</li> </ul>



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Blue Care Network**  
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### Section 6: Application Signature

I certify that:

- All required certificates and licensures are current and valid
- The information contained in this application is complete and accurate
- I understand that BCBSM/BCN may do an on-site survey after review of this application to verify program compliance and to verify the accuracy of any information provided.
- Employed and contracted health care professionals are covered under the facility's general liability insurance or maintain professionals liability insurance of \$100,000/\$300,000 limits.

*Print or Type Name	*Authorizing Signature	*Title	*Date
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