Blue Cross Blue Shield Blue Care Network of Michigan

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

FACILITY PROVIDER RECREDENTIALING

	Type 2 National provider identifier	Tax Identification Number

Section 1: Demographic Data

*denotes a required field

*Provider Name

*What type of Facility are you? (select 1 per application)

- ☐ Acute Care Hospital
- ☐ Ambulatory Infusion Center
- ☐ Ambulatory Surgery Facility
- ☐ Critical Access Hospital
- ☐ End-Stage Renal Disease
- ☐ Federally Qualified Health Center
- ☐ Halfway House
- ☐ Home Health Care
- ☐ Home Infusion Therapy
- ☐ Hospice
- ☐ Long-Term Hospital
- ☐ Outpatient Physical Therapy Facility
- ☐ Outpatient Psychiatric Care Facility
- ☐ Psychiatric Hospital
- ☐ Psychiatric Residential Treatment Facility
- ☐ Rehabilitation Hospital
- ☐ Rural Health Clinic
- ☐ Skilled Nursing Facility
- ☐ Substance Abuse Facility

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:

Substance Abuse Facility

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 if detoxification services are provided?) ☐ 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

Provider Classification	Required Accreditations and CMS/Medicare documents
• Ambulatory Surgery Facility	☐ AAAHC - Accreditation Association for Ambulatory Health Care ☐ AAAASF - American Association for the Accreditation of Ambulatory Surgery Facilities ☐ 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

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

• Ambulatory Infusion Center	☐ ACHC - Accreditation Commission for Health Care ☐ CHAP - Community Health Accreditation Program ☐ TJC - The Joint Commission
• Halfway House • Outpatient Psychiatric Care Facility • Substance Abuse Facility	☐ AAAHC - Accreditation Association for Ambulatory Health Care ☐ COA- Council on Accreditation of Services for Famililies and Children ☐ CARF- Commission on Accreditation of Rehabilitation Facilities ☐ HFAP- Healthcare Facilities Accreditation Program ☐ TJC- The Joint Commission
• Home Health Care Facility • Skilled Nursing Facility • End Stage Renal Disease Facility • Federally Qualified Health Centers • Rural Health Clinic	☐ 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
• Home Infusion Therapy	☐ 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
• Hospice	☐ 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
• Acute Care Hospital • Critical Access Hospital • Long-Term Hospital • Psychiatric Hospital • Rehabilitation Hospital	☐ 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
• Outpatient Physical Therapy	☐ 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 2: Professional ID/Required Documents/Accreditations/Organizations continued

Malpractice Insurance

All facilities must maintain a level of medical liability insurance of $500,000/$1,000,000 limits and general liability insurance in the amount of $1,000,000/$2,000,000. Please provide copies of both policy face sheets.

Current General Liability coverage (occurrence) _____ (per aggregate) _____

Expiration Date	Liability Coverage is renewed: ☐ Annually ☐ Continuous

Current Medical Liability coverage (occurrence) _____ (per aggregate) _____

Expiration Date	Liability Coverage is renewed: ☐ Annually ☐ Continuous

Are physicians, practitioners and professional clinicians covered under the malpractice insurance? ☐ Yes ☐ No

Carrier Name

Section 3: Address Data (If more locations please list in Section 3)

*denotes a required field

Primary address (must be an address where health care services are rendered and may be published in BCBSM/BCN provider directories)

*Street Address		
*City	*State	*Zip Code

Primary Telephone Number must be a phone number patients can call to make an appointment.

*Primary Telephone Number	Fax Number

Primary address - Accessiblity

*Handicap accessibility: ☐ Yes ☐ No *Accessible by bus: ☐ Yes ☐ No

Credentialing Contact information

Please provide the name and contact information of a person who can answer questions about information in this application

* First Name	Last Name
* Telephone Number extension	Fax Number
Email	Preferred method of contact? ☐ Email ☐ US Mail Click here for explanation

Primary Address – Office Hours

Office Hours	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Open Time							
Close Time							

	Type 2 National provider identifier	Tax Identification Number

Section 3: Address Data continued

*denotes a required field

Additional Location 2 address (must be an address where health care services are rendered and may be published in BCBSM/BCN provider directories)		
*Street Address		
*City	*State	*Zip Code
Primary Telephone Number must be a phone number patients can call to make an appointment.		
*Primary Telephone Number	Fax Number	

Additional Location 2 address - Accessiblity	
Credentialing Contact information Please provide the name and contact information of a person who can answer questions about information in this application	
* First Name	Last Name
* Telephone Number extension	Fax Number
Email	Preferred method of contact? ☐ Email ☐ US Mail

Additional Location 2 – Office Hours							
Office Hours	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Open Time							
Close Time							

	Type 2 National provider identifier	Tax Identification Number

Section 3: Address Data continued

*denotes a required field

Additional Location 3 address (must be an address where health care services are rendered and may be published in BCBSM/BCN provider directories)		
*Street Address		
*City	*State	*Zip Code
Primary Telephone Number must be a phone number patients can call to make an appointment.		
*Primary Telephone Number	Fax Number	

Additional Location 3 address - Accessiblity	
Credentialing Contact information Please provide the name and contact information of a person who can answer questions about information in this application	
* First Name	Last Name
* Telephone Number extension	Fax Number
Email	Preferred method of contact? ☐ Email ☐ US Mail

Additional Location 3 – Office Hours							
Office Hours	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Open Time							
Close Time							

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Section 4: Facility Ownership

Additional Ownership Questions

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

Staffing

Medical Director name	License number
Medical Director credentials (MD, DO, Specialty)	Medical Director Type 1 NPI

Section 4: Facility Ownership and Staffing continued

General

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

Application Attachments/Checklist

___ Copy of Facility License
___ Copy of current Professional and General Liability Insurance
___ Copy of Accreditation Certificate and/or Accreditation Approval Letter
___ If not accredited, most recent copy of CMS recertification survey or a copy of the CMS letter showing substantial compliance for applicable facilities
___ Copy of CMS Medicare Certification Letter for applicable facilities
___ Certificate of Need (CON) required for PE Scanners, MRI, and Megavoltage Radiation Therapy
___ Registration and certificate/inspection information for mammography, x-ray machines & all other ionizing equipment
___ Copy of DEA license (for Substance Abuse facility licensed for Methadone)

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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

When Completed