Blue Care Network of Michigan
Facility and Ancillary Application,
Recredentialing Application and Change Form

This form can be used for the following:

1. Brand new providers applying for participation in the BCN HMO, BCN Advantage or Blue Cross Complete network(s)
2. Existing Providers
   A) To complete the Recredentialing application
   B) To change ownership, tax ID and/or NPI number
   C) To add a line of business
   D) To terminate a line of business

1) BRAND NEW PROVIDERS

If you are a brand new provider applying for the first time, we thank you for your interest in participating in Blue Care Network of Michigan (BCN). Please complete the attached application <u>for each unique NPI</u>. An application for each unique NPI must be completed in its entirety (with all attachments submitted). Incomplete applications will be returned to the provider and may delay the approval process. Please fax or mail your completed application to Blue Care Network, Mail Code B258, 4520 Linden Creek Parkway, Suite A, Flint, MI 48507. Phone: (800) 527-1906; Fax: (810) 720-8627.

Upon receipt of your application, BCN will review against program criteria and make a disposition regarding acceptance or denial of the application. Completion of this application does not imply acceptance into BCN's network of providers. You may not submit claims and are not eligible for payment under BCN until you are credentialed by BCN and both parties sign a provider affiliation agreement.

2) EXISTING PROVIDERS

A) Recredentialing
If you are an existing contracted provider with BCN, you can use this application to complete your recredentialing requirements. Please complete the application in its entirety for each unique NPI and fax it to 877-297-5134.

B) Demographic Change Requests
All demographic changes need to be submitted on your facility's letterhead to BCBSM Provider Contracting via fax at 866-393-8533 or mail to Blue Cross Blue Shield of Michigan, Provider Contracting, 600 E. Lafayette Blvd, MC 513E, Detroit, MI 48226-2998. Please describe the change in your letter and include all the following information:

- Signature of an authorized representative
- Name of facility
- NPI
- Effective date of change
- Printed name and title of authorized representative
- Facility code
- Federal tax ID number
- Contact person's name, phone number and e-mail address

If you are changing your Tax ID# and/or NPI Number, in addition to submitting the change to BCBSM Provider Contracting, please also submit a brand new application to BCN and follow the instructions above for brand new providers.

C) Request to Add a Line of Business
If you are an existing contracted provider with BCN, you can use this application to request to contract with an additional BCN line of business (HMO Commercial, BCN Advantage or Blue Cross Complete). You only need to complete sections 1, 2 and 9 of this application.

D) Request to Terminate a Line of Business
If you want to remove a BCN line of business, please submit a letter on your facility's letterhead directly to BCN to the location listed in your contract or to the address listed in the "Brand New Providers" section above. Please indicate which line of business you want to terminate and include the same information outlined in 2(B) above.

Section 1: APPLICATION PURPOSE

(Select only one of the four-numbered items below; A separate application is required for each function)

1) ☐ Brand New Provider
Select Product(s): ☐ HMO Commercial ☐ BCN Advantage ☐ Blue Cross Complete
Indicate date open for business:____________________

2) ☐ Existing Provider submitting the Recredentialing Application

3) ☐ Existing Provider adding a Line of Business (you only need to complete sections 1, 2 and 9)
Select Product to add: ☐ HMO Commercial ☐ BCN Advantage ☐ Blue Cross Complete

4) ☐ Existing Provider Changing Ownership, NPI and/or Tax ID

Old NPI:______________________________ New NPI:______________________________

Old Tax ID:____________________________ New Tax ID:____________________________

Section 2: DEMOGRAPHICS

Facility Name: ____ d/b/a: ____

Primary Practice Address:____

City: ________________________ State: ___________ Zip Code: _________________County: __________________

Phone #: (_____)______________________________Fax #: (_____)________________________

E-mail Address:____

Additional Practice Address*:____

City: ________________________ State: ___________ Zip Code: _________________County: __________________

Phone #: (_____)______________________________Fax #: (_____)________________________

E-mail Address:____

Unique NPI# (if applicable):____

*Please attach additional pages if you have more practice addresses associated with this NPI if you are **applying for the first time,** since each practice address must be credentialed by BCN. Also, each unique NPI number requires a separate application.

Mailing Address: ____

City: ________________________ State: ___________ Zip Code: _________________County: _________________

Mailing Contact Name/Title: ____

Mailing Contact Phone #: (____)_________________ Mailing Contact Fax #: (____)__________________

Credentialing Contact Name/Title:____

Credentialing Contact Phone#:(_______)_________________Credentialing Contact Fax #: (____)______________________

Credentialing Contact Email:____

Remit Address: ____

City: ________________________ State: ___________ Zip Code: _________________County: __________________

Remit Contact Name/Title: ____

Remit Contact Phone #: (____)__________________ Remit Contact Fax #: (____)____________________

BCBSM#: ______________________________ (If you do not have a BCBSM Pin #, you will need to submit a W-9)

Federal EIN: ____________________________

NPI #: __________________________________

Medicare #:______________________________ CMS Effective Date: ________________

Medicaid #:______________________________

State License #:__________________________ State License Issue Date: ______________

Section 3: FACILITY/ANCILLARY OWNERSHIP

While not a condition for participation in itself, a statement of ownership and status is required to allow BCN to evaluate the facility's organization. List the names, percentage(s) of ownership and addresses of all owners of the facility.

Name	Address	Percentage Owned

Section 4: STAFFING

A specific physician Medical Director must clearly be identified as responsible for management in accord with policies established by the governing body. The Medical Director must be licensed in good standing in the state of Michigan and in good standing with BCN.

Medical Director Name: ____________________________________ License No.: ______________________________

Credentials (MD, DO; Specialty)____

Administrator Name: ____

Nursing Director Name: ____________________________________ License No.: ______________________________

Are the medical staff credentialed through an: Internal Process: ________ Outside Agency: ________

If an Outside Agency was used, please provide the name of the Agency: ____

Section 5: HOURS OF OPERATION

Posted hours of Operation:

Monday:	_____to _____
Tuesday:	_____to _____
Wednesday:	_____to _____
Thursday:	_____to _____
Friday:	_____to _____
Saturday:	_____to _____
Sunday:	_____to _____
Holidays:	_____to _____

Section 6: FACILITY/ANCILLARY TYPE

Facility/Ancillary Type (please check one). For services listed below your facility/ancillary type, please check off any that you provide. Definitions of each provider type begin on page 7:

☐ Ambulance
☐ Air ☐ Ground

☐ Ambulatory Surgery Facility
Please List the Anesthesiology Group Name(s) and NPI(s) who practice at your facility:
1. ______________________________NPI______________________
2. ______________________________NPI______________________
3. ______________________________NPI______________________

☐ Dialysis

☐ Federally Qualified Health Center

☐ Free Standing Radiology Center **(indicate specific services provided):**
☐ Bone Density ☐ CT Scan ☐ Fluoroscopy ☐ Mammography ☐ Mobile Unit
☐ MRI of breast ☐ MRI ☐ MRI – Open ☐ PET Scan ☐ Nuclear Medicine
☐ Radiation Oncology ☐ Routine X-Ray ☐ Ultrasound
Do you perform diagnostic testing or read test results only? ☐ Diagnostic Testing ☐ Read-only

☐ Halfway House

☐ Health Department

☐ Home Health
☐ Adults ☐ Pediatrics ☐ Telemonitoring

☐ Home Infusion Therapy
☐ Adults ☐ Pediatrics ☐ Implanted pain or Baclofen pump management

☐ Hospice

☐ Hospital

☐ Long Term Acute Care Hospital (LTACH)

☐ Outpatient Physical Therapy (includes Physical, Occupational, & Speech Therapy)

Does the OPT have practitioners who treat Autism Spectrum Disorders? ☐ Yes ☐ No

☐ Rural Health Clinic

☐ Skilled Nursing/Nursing Home **(indicate specific services provided onsite):**
☐ Bariatric Patients ☐ Blood Transfusions ☐ Hemodialysis ☐ High Level Oxygen
☐ IV Therapy ☐ Peritoneal Dialysis ☐Tracheostomy ☐ Vent
☐ Wound Care

☐ Urgent Care Center **(indicate specific services provided):**
☐ Casting ☐ Clia Waived Rapid Tests ☐ Laceration repair ☐ Splinting ☐ Stitching
☐ On-site Crash Cart ☐ On-site Lab ☐ On-site Defibrillator ☐ On-site X-ray

If On-site X-ray was selected, does a Board Certified Radiologist read the x-rays? ☐ Yes ☐ No

List name of Radiologist or Radiology Group who reads the x-rays___________________________________

Is the Urgent Care Center free-standing or hospital-owned? ☐ Free-Standing ☐ Hospital-owned
Is there a physician onsite at all times? ☐ Yes ☐ No
Is there an ACLS certified practitioner onsite at all times? ☐ Yes ☐ No

What is the staffing ratio for this site? (Staff: MD) _____________

Identify total number of staff who works at this site, as well as number of staff per shift:

Staff Type	Total	Per Shift
MD		
PA		
RN		
ER RN		
Med Asst.		
Other (specify)		

Does this site also have a physician practice that accepts referrals or provides primary care services? ☐ Yes ☐ No

Section 7: ACCREDITATION STATUS

Accredited By:

☐ AAAHC ☐ ACHC ☐ ACR ☐ ADA ☐ AOA ☐ CARF ☐ CCAC ☐ CHAP
☐ COA ☐ DNVHC ☐ HFAF ☐ JCAHO ☐ Public Health Department ☐ Other:

Effective Date: ________________________ Expiration Date: ___________________________

N/A: ☐ If <u>not accredited</u> by one of the above agencies, please provide a copy of your most recent **<u>CMS survey</u>** or a copy of the CMS Letter showing that your facility is in **substantial compliance**.

Section 8: MALPRACTICE / INSURANCE

All Hospitals must maintain $5,000,000 of combined single limit professional liability insurance and $5,000,000 of combined single limit general liability insurance or professional liability insurance (which includes general liability coverage) of $5,000,000 combined single limit.

All other facilities must maintain a level of medical liability insurance in the amount of $500,000/$1,000,000 and general liability insurance in the amount of $1,000,000/$2,000,000. Please provide copies of both policy face-sheet(s).

Current <u>Medical</u> Liability Coverage (occurrence) ____________________ (per aggregate) _______________________

Expiration Date: ___________________ Liability Coverage is renewed: _______Annually _______Continuous

Current <u>General</u> 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:____

Please indicate coverage amounts: ____________________ (per occurrence) _____________________ (per aggregate)

Section 9: ATTESTATION

I certify by my signature the following:

- The information contained in this application is complete and accurate.
- All required certificates and licensures are current and valid
- The facility must have an organized medical staff, established in accordance with policies and procedures developed by the facility, which will be responsible for maintaining proper standards of medical care. Criteria for membership on the medical staff must be established and enforced by a credentials evaluation program established by the facility and approved by BCN.
- Witten criteria for participation on medical staff exist for your facility
- All employed and contracted health care professionals maintain current State of Michigan licenses or certifications as required for their positions. All staff members are licensed or certified as required for their positions.
- Employed and contracted health care professionals are covered under the facilities general liability or maintain a professional liability insurance of $100,000/$300,000 limits.
- All required policies and procedures have been implemented and are enforced by this facility.
- Documentation regarding any of the information contained in this application will be produced upon request.
- The facility will do its utmost to notify BCN of any relevant changes that may occur that would alter the responses provided in this application
- The facility will comply with any additional requests for information, documentation, or onsite reviews necessary to credential and/or recredential the site.
- BCN shall be held harmless from any claims, lawsuits, etc. that arises as a result of the misrepresentation of information provided in response to this application.
- I understand and agree that I as an applicant for BCN, have the burden of producing adequate information for the proper evaluation of credentials, including professional competence, character, ethics, and other qualifications, and am responsible for resolving any doubts about qualifications.
- Neither the facility nor its managing employees, officers, directors, or major shareholders/owners (i.e. person with beneficial ownership of 5% or more) appear in either the List of Excluded Individuals/Entities as published by the United States Department of Health and Human Services Office of the Inspector General, in the List of Debarred Contractors as published by the United States General Services Administration (GSA), nor in the Michigan Medicaid Sanction list.
- In addition, if facility is applying for Blue Cross Complete, neither the facility nor its managing employees, officers, directors, or major shareholders/owners (i.e. person with beneficial ownership of 5% or more) appear in the Social Security Administration’s Death Master File; the National Plan and Provider Enumeration System (NPPES); the Medicare Exclusion Database (MED); the Michigan Department of Community Health (MDCH)/Medical Services Administration (MSA) Sanctioned Provider List; the Licensing and Regulatory Affairs (LARA) Disciplinary Action Report (DAR); and any other database as the Secretary of HHS may prescribe. Nor has facility, its managing employees, officers, directors, partners, agents, or major shareholders/owners (i.e. person with beneficial ownership of 5% or more) been suspended, debarred, or otherwise excluded under the Federal Acquisition Regulation as described in 42 CFR 438.610.
- There are no pending investigations, legal actions, or matters subject to arbitration involving facility or its managing employees, officers, directors, or major shareholders/owners (i.e. person with beneficial ownership of 5% or more) on matters relating to payments from governmental entities, both federal and state, for healthcare and/or prescription drug services. Additionally, neither facility nor its managing employees, officers, directors, or major shareholders/owners (i.e. person with beneficial ownership of 5% or more) have been criminally convicted or have had a civil judgment entered against them for fraudulent activities.

Note: This form must be signed by the person who is responsible for the overall administration and enforcement of policy at your facility.

Signature:____Date:__________________________

Printed Name:____

Title:____ Phone Number: ____________________________

Please remember to attach the following documents for all application requests (unless otherwise noted):

____Copy of Facility License

____Copy of current Professional & General Liability Insurance

____Copy of Accreditation Certificate

____ If not accredited, most recent copy of CMS survey or a copy of the CMS Letter showing substantial compliance

____Medicare Provider Number Letter (required when requesting BCNA)

____ Certificate of Need (CON) required for Air Ambulance, PET Scanners, MRI, Megavoltage Radiation Therapy

____ Copy of W-9 only if you do not have a BCBSM Pin# (not necessary for recredentialing)

____ Registration and certificate/inspection information for mammography, x-ray machines & all other ionizing equipment

____ CLIA Certificate (Hospitals, Urgent Care Centers, Clinical Laboratories and in-office performed labs only)

Please also send a photograph of the exterior of your facility to bcnproviderpictures@bcbsm.com for our website if you have not already done so. The photos should be digital and meet these specifications:

- Size: 156 pixels wide x 125 pixels tall
- Resolution between 150 and 300 dots per inch (dpi)
- File type should be .jpg, .bmp or .psd
- There should be no borders around the photo
- File size should be less than 200K

DEFINITIONS

Ambulance
Ambulance providers who provide transportation and life support services furnished to sick, injured or incapacitated patients by a licensed ambulance company and personnel recognized as qualified to perform such services at the time and place where rendered. Ambulance services may involve ground or air transport in both emergency and non-emergency situations.

Ambulatory Surgery Facility (ASF)
A freestanding outpatient surgery facility licensed by the State of Michigan and certified by CMS. An ASF provides elective outpatient surgery and related care that can be safely performed without overnight inpatient care. Physicians' offices and other private practice offices are not considered ambulatory surgery facilities. BCNs Ambulatory Surgery Facility program covers only those surgical procedures identified by BCN as appropriate for an ambulatory surgery facility. Eligible procedures are limited to those that can safely and appropriately be performed in an outpatient setting at the facility and that are not usually performed in physicians' offices.

Dialysis Facility
A facility that is certified by the State of Michigan and Centers for Medicare and Medicaid Services (CMS) to provide dialysis services. The dialysis facility can perform hemodialysis, peritoneal dialysis and home hemodialysis training. Additional support services may be required to provide proper care.

Federally Qualified Health Center (FQHC)
A federally qualified health center (FQHC) is a type of provider defined by the Medicare and Medicaid statutes. FQHCs include all organizations receiving grants under Section 330 of the Public Health Service Act, certain tribal organizations, and FQHC Look-Alikes.

Free Standing Radiology Center
A freestanding, non-urgent facility that is separate from a hospital, where diagnostic services, such as MRI, PET, x-ray, mammography and CT services are performed. Ambulatory patients can receive outpatient therapeutic and diagnostic radiology services, which vary by location, at these facilities as well. All freestanding radiology facilities are subject to credentialing standards established by Blue Care Network. All facilities are expected to bill on a global basis (technical + professional); CMS 1500.

Halfway House
Any private or public agency under contract to the Department of Public Safety or the Department of Corrections to provide residential and/or non residential treatment and transitional services for Department of Corrections offenders.

Health Department
A facility that is certified by the State of Michigan and Centers for Medicare and Medicaid Services (CMS) to provide immunizations to members.

Home Health
A Home Health Agency is an organization primarily engaged in providing skilled nursing services and other therapeutic services to patients in their own homes.

Home Infusion Therapy
Agencies that provide infusion therapy to patients in non-hospital settings, including but not limited to nursing homes, sub-acute care facilities, rehabilitation facilities or at home.

Hospice Provider
A hospice is a public or private program that provides medical, psychological, social and spiritual services to terminally ill patients and their families. Hospice care focuses on providing treatment that reduces or relieves the physical and psychosocial symptoms of a patient's terminal disease, rather than actively seeking a cure. This type of care is also referred to as palliative care. Blue Care Network of Michigan will only authorize hospice care after a member's physician refers the member to hospice and the member elects hospice treatment.

Hospital
A hospital is a facility offering inpatient, overnight care, and services for observation, diagnosis, and active treatment of an individual with a medical, surgical, obstetric, chronic, or rehabilitative condition requiring the daily director or supervision of a physician.

Long Term Acute Care Hospital
A Long Term Acute Care Hospital (LTACH) provides a level of care that is more intensive than that provided by most Skilled Nursing Facilities. An LTACH specializes in providing care when a short-term acute hospital stay is no longer required or not the most appropriate setting based on the patient's clinical needs.

Outpatient Physical Therapy (OPT)
A freestanding outpatient physical therapy facility that is not owned or operated by a hospital or a hospital PT department. Services that may be provided include physical therapy, occupational therapy and speech therapy.

Rural Health Clinic
A rural health clinic is a Medicare certified clinic located in a rural area having a shortage of health manpower, a shortage of personal health services, or high migrant worker impact. These clinics are typically staffed by mid-level practitioners under physician supervision.

Skilled Nursing Facility
A skilled nursing facility is a Medicare-certified and Michigan-licensed facility that provides an intermediate level of care for an illness or injury that can be successfully treated without hospitalization, but that requires a more intensive level of care than home health care. It does not include a unit in a hospital, veteran's facility, or hospice.

Urgent Care Center (UCC)
An urgent care center is defined as a medical facility where ambulatory patients can be treated on a walk-in basis without an appointment and receive immediate, non-routine urgent care. This does **not** include primary care physician or specialist office sites offering after-hours or extended hours care. Urgent Care Centers owned and operated by a hospital who are included in the hospital's accreditation will be credentialed by BCN, but a site visit will not be required. A separate contract will also be issued.