Instructions for fax cover sheet

We cannot accept handwritten forms. Do not hand write anywhere on the forms, otherwise processing will be delayed.

To ensure forms are processed timely, please adhere to the following instructions:

- **For Facilities**
  - From (Insert name of contact person)
  - Date (MM/DD/YYYY)
  - Type 2 National Provider Identifier
  - Tax identification number

Instructions for document submission

1. Fax cover sheet must be the first page of your form submission.

2. Fax the registration form and attachments (i.e., signature document) to **1-866-900-0250**. Be sure to fax the registration information separately for each provider. (For example: If you register two or more providers, you must send a fax for each provider. They cannot be bundled into one fax transmission.)

Questions? Call 1-800-822-2761

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Blue Cross Blue Shield Blue Care Network of Michigan

FAX COVER SHEET FOR DOCUMENTS

IMPORTANT: Attach this page to the top of your document to avoid processing delays.

Fax To: **866-900-0250 Provider Enrollment**

From:

Date:

Form Number: 12590

Type 1 NPI:

Type 2 NPI:

Tax Identification Number:

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NEW FACILITY PROVIDER ENROLLMENT

Tax Identification Number	Type 2 National Provider Identifier

Section 1: Demographic Data

*denotes a required field

*Provider (d.b.a.) Name	
*What type of Provider/Facility are you: (select 1 per application) Ambulatory Infusion Center Ambulatory Surgery Facility End-Stage Renal Disease Federally Qualified Health Center Halfway House Home Health Care Home Infusion Therapy Hospice	Long-Term Acute Care Hospital Outpatient Physical Therapy Facility Outpatient Psychiatric Care Facility Psychiatric Residential Treatment Facility Rural Health Clinic Skilled Nursing Facility Substance Abuse Facility
Indicate date your facility/location will open or has opened for business:	
*County where your primary address is located	Fiscal Year End (F.Y.E.)
Website	ESRD (ONLY) Corporate Ownership
Facility Status: Hospital based	Freestanding
Federal Tax Identification Number	Tax Name
Medicare Number	Medicaid Number
Tax Status: Non-exempt	Exempt - If exempt, attach supporting IRS document
Are you considered an Essential Community Provider under the Affordable Care Act?	Yes No

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Section 2: Requested Networks

If applying to participate with Traditional, Trust PPO, Medicare Advantage℠ Private Fee For Service, Medicare Advantage℠ PPO, please keep a copy of the agreement for your records and please return a Signature Document for each eligible network. If applying to participate in BCN Commercial or BCN Advantage℠ HMO, contracts will be sent under separate cover.

You will be notified of your status in BCBSM and BCNs networks after credentialing is completed. The signatures on the letter serve as BCBSM's counter signature on the signature document thereby creating a final contract between you and BCBSM. For BCN, you will receive the countersigned affiliation agreements.

BCBSM and BCN do not permit retroactive effective dates.

Select networks you are applying to:

Facility Type	Eligible Networks for Facility Type	
Ambulatory Surgery Home Health Care	Traditional-participating Traditional-nonparticipating Medicare Advantage℠ PPO Medicare Advantage℠ Private Fee For Service	Medicare Supplement (for HHC only) BCN Advantage℠ HMO BCN Commercial
End-Stage Renal Disease Outpatient Physical Therapy	Traditional-participating Traditional-nonparticipating Medicare Advantage℠ PPO Medicare Advantage℠ Private Fee For Service	Medicare Supplement BCN Advantage℠ HMO BCN Commercial Trust PPO
Federally Qualified Health Center	Medicare Advantage℠ Private Fee For Service Medicare Advantage℠ PPO Medicare Supplemental	BCN Advantage℠ HMO BCN Commercial
Halfway House	State of Michigan Mental Health and Substance Abuse	
Home Infusion Therapy Ambulatory Infusion Center	Traditional-nonparticipating BCN Advantage℠ HMO	Medicare Advantage PPO
Hospice	Traditional-participating Traditional-nonparticipating	Medicare Supplemental BCN Commercial
Long-Term Acute Care Hospital Skilled Nursing	Traditional-participating Traditional-nonparticipating Medicare Advantage℠ PPO Medicare Advantage℠ Private Fee For Service	Medicare Supplement BCN Advantage℠ HMO BCN Commercial
Outpatient Psychiatric Care Substance Abuse	Traditional-participating Traditional-nonparticipating State of Michigan Mental Health and Substance Abuse	BCN Advantage℠ HMO BCN Commercial
Psychiatric Residential Treatment Facility	Traditional-participating Traditional-nonparticipating	BCN Advantage℠ HMO BCN Commercial
Rural Health Clinic	Medicare Advantage℠ Private Fee For Service Medicare Advantage℠ PPO Medicare Supplemental	BCN Advantage℠ HMO BCN Commercial

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NEW FACILITY PROVIDER ENROLLMENT

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Section 3: Professional ID/Required Documents/Accreditations/Organizations

Please attach required professional identification required documents, and accreditations with this application.

Click here for the comprehensive list of required documents. All of the information requested is required in order to be enrolled with BCBSM and/or BCN. Your application will not be processed if any pieces of information are missing.

Malpractice Insurance - BCN Networks Only			
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
Malpractice Carrier Name			

Section 4: Address Data

*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. Primary address cannot be a PO Box)		
*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	

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NEW FACILITY PROVIDER ENROLLMENT

Tax Identification Number	Type 2 National Provider Identifier

Section 4: Address Data *(continued)*

*denotes a required field

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 address	Preferred method of contact Email US Mail

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

Payment/Remit address		
*Street Address		
*City	*State	*Zip Code
Payment/Remit telephone number *(if different from your Primary telephone number)*		

Mailing address		
*Street Address		
*City	*State	*Zip Code
*Mailing contact name	*Mailing contact phone number	

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NEW FACILITY PROVIDER ENROLLMENT

Tax Identification Number	Type 2 National Provider Identifier

Section 4: Address Data *(continued)*

*denotes a required field

Medical Records Request (MRR)

Street Address		
City	State	Zip Code
Contact Name - First	Middle	Last
Telephone	Fax	Email

Additional Location 2 address (must be an address where health care services are rendered and may be published in BCBSM/BCN Provider directories. Service address cannot be a PO Box)

*Street Address		
*City	*State	*ZIP Code

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

*What name do you use when you answer the phone for this practice location?	
*Primary Telephone Number	Fax Number

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 address	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							

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NEW FACILITY PROVIDER ENROLLMENT

Tax Identification Number	Type 2 National Provider Identifier

Section 4: 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. Service address cannot be a PO Box)

*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

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 address	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							

Section 5: Facility Ownership Changes

Is this a recent change of ownership recognized by Medicare? Yes No

If ***Yes***, please complete Medicare Approved Change of Ownership below:

If ***No***, please complete Section 5A Facility Ownership.

Ownership Changes:

- Medicare Recognized Ownership change: Change in the facilities Tax ID and NPI.
- Buyer: Complete the BCBSM/BCN New Facility Enrollment Form.
- Seller: Complete the BCBSM/BCN Facility Provider Termination Form.
- Medicare Recognized Stock Transfer: No changes in Tax ID or NPI. Stock transfers include internal changes such as adding or deleting individuals/corporations that are recognized by CMS.
- Complete the BCBSM/BCN Facility Provider Change Form. Include a copy of the Medicare approval letter.

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Section 5A: Facility Ownership

Facility Ownership

List name/organization, address, occupation and percentage of ownership. Ownership percentage must equal 100%. Attach additional ages if needed.

Name	Business Address	Occupation	Percent

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 the facility included in the hospital organization chart? Yes No

Are the facility's charges and costs included in the hospital cost report? Yes No

Are the facility's utilization evaluation and/or quality assurance plans included in the hospital's utilization review program? Yes No

If ***Yes***, to above questions, please provide the BCBSM hospital facility code: ______________________________

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
Nursing Director Name	License number

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

If Outside Agency is used, please provide the agency's name: ______________________________

Does the facility have a governing or advisory board? Yes No

Does the facility's governing or advisory board include community representation? Yes No

Please provide a complete staff roster for your facility including names, credentials, job titles, and license numbers for all professional/clinical staff members.

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NEW FACILITY PROVIDER ENROLLMENT

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General		
Has the facility or an office, 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 6: Services

Ambulatory Surgery Facility

NOTE: The BCBSM EON has been suspended.

Does the facility have a written agreement with an area hospital for the prompt transfer of patients? Yes No

Please identify the name of the hospital: ____________________

Is a Michigan licensed physician always on site when patients are on the facility premises? Yes No

List the number of Operating Rooms*: ____________________

**Operating Room is defined as being located in a sterile corridor that is licensed as an operating room by the State of Michigan.*

Please list Name and NPI of the Anesthesiology Groups who practice at your facility:

Name	NPI
1.	
2.	
3.	

End Stage Renal Disease

List the number of dialysis stations at your facility: ____________________

Does your ESRD facility provide:

Home Hemodialysis services?	Yes	No
In-Facility Hemodialysis servces?	Yes	No
Peritoneal Dialysis?	Yes	No

Servicing Questions by Facility Type continued on next page

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NEW FACILITY PROVIDER ENROLLMENT

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Federally Qualified Health Center/Rural Health Clinic

Please indicate specific services provided:

Behavioral/Mental Health onsite   Dental onsite   Pharmacy onsite   OB/GYN onsite

Primary Care onsite   Lab onsite

Halfway House

Please identify the following: # of male beds ____________   # of female beds ____________

Check the psychotherapy and counseling services provided at your facility:

Didactics   Group   Individual   Self-help group therapy

Treatment not provided   Other (describe): ______________________________

Home Health Care

Select Age Ranges Treated: 0 - 17 (Pediatric)   18+ (Adult)

Please indicate specific services provided:

Certified Psychiatric Nurse   Occupationl Therapy   Speech Therapy

Ambulatory Infusion Center
Home Infusion Therapy

Select Age Ranges Treated: 0 - 17 (Pediatric)   18+ (Adult)

Please indicate specific services provided:

Implanted pain **or** Baclofen Pump Management

Hospice

Check the box next to the levels of care provided by the facility either directly or on a contracted basis:

Routine Home Care   Continuous Home Care   Inpatient Respite Care

General Inpatient Care   Nursing Home care with Hospice support (5th level)

Where care is provided on a contracted basis, provide the name of the contracted facility:

____

Long-Term Acute Care Hospital

Does the facility have a written agreement with an area hospital for the prompt transfer of patients?   Yes   No

Please identify the name of the hospital: ______________________________

Outpatient Physical Theray (Check which services are provided at your facility):

Physical   Occupational   Speech

Indicate the date the facility began providing services to patients (must be operational for 6 months prior to application being submitted to BCBSM): ______________________________

Treats patients with autism spectrum disorder?   Yes   No

Skilled Nursing Facility (indicate specific services provided onsite)

Bariatric Patients   Peritoneal Dialysis   Vent

IV Therapy   Hemodialysis   Total Parenteral Nutrition

Wound Care   High Level Oxygen

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Section 6: Behavioral Health Services

Telehealth Services	
Telehealth - Audio/Visual	Telehealth - Telephone Only

Outpatient Psychiatric Care

Do you have a board-certified child or adolescent psychiatrist on staff? Yes No

Do you have a licensed behavior analyst (LBA) who performs applied behavior analysis treatment for autism spectrum disorders? Yes No

Select Patient Age Ranges Treated:

0-12 Child 13-17 Adolescent 18-64 Adult 65+ Geriatric Other: ______________

Check all Psychiatric Levels of Care that apply:

- Partial Hospitalization Mental Health (PHP)
- Intensive Outpatient Mental Health (IOP)
- Mobile Crisis
- Crisis Stabilization
- Mental Health Outpatient Services

Approved Autism Evaluation Center (AAEC)

If you are interested in becoming an Approved Autism Evaluation Center (AAEC), please go to Provider Portal to learn more: **https://ereferrals.bcbsm.com/docs/common/common-letter-of-intent-to-request-RFP-AAECs-no-deadline.pdf**

Psychiatric Residential Treatment Facility (PRTF)

Are you licensed in Michigan as Child Care Institution? Yes No

Adult Foster Care Facility? Yes No

If other licensure, please indicate type: ______________________________

Select Patient Age Ranges Treated:

0-12 Child 13-17 Adolescent 18-64 Adult 65+ Geriatric Other: ______________

Does the facility have a policy and procedural process to facilitate timely and coordinated transfer of patients needing acute medical care? Yes No

Please identify the name of the hospital: ______________________________

	Tax Identification Number	Type 2 National Provider Identifier

Section 6: Behavioral Health Services

Substance Use Facility

Substance Use Residential Services (24/7 Nursing Required)

Substance Use Outpatient Services

Select Patient Age Ranges Treated:

0-12 Child 13-17 Adolescent 18-64 Adult 65+ Geriatric Other: ______________

Check the box to identify the type of programs offered:

Appropriate Michigan licensure is required for all programs or services provided:

Sub-Acute Detox

Intensive Outpatient Substance Use (IOP)

Inpatient Substance Use

Partial Hospitalization (PHP)

SAMHSA certified Opioid Treatment Program (OTP) - select applicable programs below:

Are you currently accepting new patients for SAMHSA Certified Opioid Treatment Program? Yes No

Methadone. Also, include proof of SAMHSA Certification.

Are you currently accepting new patients for Methadone Medication Assisted Treatment? Yes No

Medication Assisted Treatment (MAT) for Opioid Use - Suboxone/Buprenorphine

Are you currently accepting new patients for Suboxone/Buprenorphine Medication Assisted Treatment? Yes No

If ***yes***, would you like to be displayed in the directory for the above services? Yes No

Medication Assisted Treatment (MAT) for Opioid Use - Vivitrol/Naltrexone

Are you currently accepting new patients for Vivitrol/Naltrexone Medication Assisted Treatment? Yes No

If ***yes***, would you like to be displayed in the directory for the above services? Yes No

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NEW FACILITY PROVIDER ENROLLMENT

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Special Areas of Interest for Outpatient Psychiatric Centers and Substance Use Facilities

In an effort to assist in matching the patient need to available providers, please indicate your facility's special areas of interest below. Select no more than ten total treatment specialties and treatment modalities. We will use this information in directing members for specific services. **Our expectation is that your practice is open and accepting new cases, if you indicate specialties below**.

By selecting the below specialties or modalities, you are attesting that you or your staff have received specialized education, training, and supervision in that specialty/modality.

Select
Treatment Specialties
ADD / ADHD
Anxiety, Phobias and Related Disorders
Autism
Bereavement / Grief / Loss
Disorders of Childhood & Adolescence
Dissociative Disorders
Eating and Feeding Disorders
Gambling Disorder
Gaming (Compulsive)
Gender / Transgender Identification
Geriatric / Older Adult Disorders
HIV / AIDS
LGBTQ+
Mood Disorders
Obsessive Compulsive and Related Disorders
Opioid Use Disorders
Pain Management
Personality Disorders
Pregnancy Challenges
Psychotic Disorders
PTSD / Trauma Disorders
Selective Mutism
Sexual Addiction
Sexual Dysfunction
Substance Use Disorders
Traumatic Brain Injury

Appropriate
Treatment Modalities
ADOS Testing (trained/qualified) for Autism
Adult Intensive Services (AIS)
Applied Behavior Analysis (ABA) for Autism
Bariatric Evaluations
Brief Dynamic Therapy
Children's Intensive Services (CIS)
Cognitive Behavioral Therapy (CBT)
Dialectical Behavioral Therapy (DBT)
Electroconvulsive Therapy (ECT)
Exposure Response Prevention (ERP) Therapy
Eye Movement Desensitization Reprocessing (EMDR)
Interpersonal Therapy
Medication Assisted Treatment (MAT) for Opioid Use – Suboxone / Buprenorphine
Medication Assisted Treatment (MAT) for Opioid Use – Vivitrol / Naltrexone
NAVIGATE
Neurofeedbck (for ADHD only)
Neuropsychological Testing
Psychological Testing
Transcranial Magnetic Stimulation (TMS)

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	Tax Identification Number	Type 2 National Provider Identifier

Section 7: Application signature

I certify that:

- **I understand the effective date of participation is the date the application is actually approved by BCBSM/BCN and is not the date the application was submitted or received.**
- 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.
- I understand the facility is not eligible to submit claims for payment until it is approved by BCBSM/BCN, both parties sign the agreement(s), and the processing systems are updated.
- I will notify Blue Cross and Blue Shield of Michigan and Blue Care Network immediately in writing of changes affecting this data.
- The authorized signer agrees that he/she has the company's designated authority to request and maintain minimum necessary Web access and is responsible for complying with all terms and conditions contained within the Provider Secured Service Use and Protection Agreement.

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