Hospital Change Form

Please complete this form by faxing it to 1-866-900-0250 if you are requesting one or more changes to your existing record with Blue Cross Blue Shield of Michigan (BCBSM) and/or Blue Care Network of Michigan (BCN). If you need further assistance or have any questions, please contact:

<table>
<thead>
<tr>
<th>For BCBSM</th>
<th>For BCN</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Eric Kropfreiter</strong></td>
<td><strong>Michael VanPutten</strong></td>
</tr>
<tr>
<td>E-mail: <a href="mailto:EKropfreiter@bcbsm.com">EKropfreiter@bcbsm.com</a></td>
<td>E-mail: <a href="mailto:MVanPutten@BCBSM.com">MVanPutten@BCBSM.com</a></td>
</tr>
<tr>
<td>Telephone: 313-448-7892</td>
<td>Telephone: 616-956-5734</td>
</tr>
<tr>
<td>Fax: 877-282-1496</td>
<td>Fax: 866-524-7126</td>
</tr>
</tbody>
</table>

You may use this form to do any of the following:
- Change hospital name, fiscal year end, operations or tax status
- Change primary, payment/remit, mailing and/or medical records addresses, phone numbers or website
- Change hospital designations, certifications or NPI
- Request additional networks
- Request to terminate networks
- Change staffing information
- Change in beds in use/operation, classification

☐ Existing Hospital Changing Ownership, EIN/Tax ID Number, Tax Name, and/or primary NPI – Must complete a new hospital application located at bcbsm.com link

### Section 1: CHANGE TO NAME, FYE, OPERATIONS, TAX STATUS

Hospital Business Name: _________________________ BCBSM Hospital Code: ________________

Hospital Tax ID#________________________________ Hospital NPI: _________________________

New Business Name*: ________________________________________________________________

* This is the name the Hospital uses when doing business, or the DBA. It will be used for the directories.

Effective Date: ______________________________________________________________________

Ceasing Operations: ___________________________ Effective Date of Closure ___________________

Fiscal Year Ending Change*: ____________________ Effective Date: _________________________

* Please attach a copy of the CMS Medicare fiscal year change approval letter.

Tax Status: For Profit _______ Exempt _______ If exempt, attach supporting IRS document.
Section 2: ADDRESS CHANGES

Main inpatient campus

New Site Address (for directory):

City: __________ State: _______ Zip Code: __________ County: ________________

Phone # (for directory): (____) __________ Website (URL) __________

New Mailing Address (if different from site address):

City: _______________ State: _____ Zip Code: _______________ County: _______________

Mailing Contact Name/Title: __________________________________________________________

Mailing Contact Phone #: (___) __________ Mailing Contact Fax #: (___) __________

New Remit Address:

City: _______________ State: _____ Zip Code: _______________ County: _______________

Remit Contact Name/Title: __________________________________________________________

Remit Contact Phone #: (___) __________ Remit Contact Fax #: (___) __________

Medical Records Request (MRR) (if different from your primary address) Check here if the same □

Street Address: _________________________________________________________________

City: _______________ State: __________ Zip Code: ______________

Contact Name First: ___________________________ Middle: ______________ Last: ______________

Telephone: __________________________ Fax: ______________________ Email: ___________________

Secondary inpatient campus

New Site Address (for directory):

City: _______________ State: _______ Zip Code: __________ County: ________________

Phone # (for directory): (___) __________ Website (URL) __________

Please attach an additional page if you have more inpatient campus address changes under the same
Tax ID and license as the primary/main campus.
Section 3: CHANGES TO DESIGNATIONS, CERTIFICATIONS, NPI

Check all changes to hospital's applicable Medicare and Medicaid designations/certifications and/or National Provider Indentifier (NPI). Please attach appropriate CMS and/or State Licensure supporting documentation:

<table>
<thead>
<tr>
<th>Medicare Designations/Certifications</th>
<th>Add</th>
<th>Delete</th>
<th>NPI</th>
<th>If an addition, CMS certification number</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Care Hospital</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Children's Hospital (excluded PPS)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Critical Access Hospital</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Exempt Psychiatric Unit or Psychiatric Hospital (excluded from PPS)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Exempt Rehabilitation Unit or Rehabilitation Hospital (excluded from PPS)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medicare Dependent Hospital</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rural Referral Center</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Short-Term (General &amp; Specialty) Hospital</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sole Community Hospital</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Swing beds</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HB - End Stage Renal Dialysis</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other (specify)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other (specify)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Section 4: REQUEST ADDITIONAL NETWORKS

You will be notified of your status and the effective dates of affiliation in BCBSM and BCN networks after credentialing for the networks is completed and BCBSM/BCN have countersigned your affiliation agreements. BCBSM and BCN do not permit retroactive effective dates in managed care networks. See Appendix 1 for further information on network descriptions.

Please select the additional network(s) to which you would like to apply:

**BCBSM Products**
- [ ] Traditional-Participating
- [ ] Traditional-Nonparticipating
- [ ] TRUST (PPO)*
- [ ] Medicare Advantage PPO (Medicare Plus Blue PPOSM)
- [ ] Medicare Supplemental
- [ ] Mental Health and Substance Abuse Managed Care Network (SOM Network)*

* To be eligible must be Traditional-Participating

**BCN Products**
- [ ] Commercial HMO
- [ ] BCN Advantage HMO-POSSM
Section 5: REQUEST TO TERMINATE NETWORKS

Please select the network(s) from which you would like to terminate. See Appendix 1 for further information on network descriptions.

BCBSM Products

☐ Traditional-Participating
☐ Traditional-Nonparticipating
☐ TRUST (PPO)
☐ Medicare Advantage PPO (Medicare Plus Blue)
☐ Medicare Supplemental
☐ Mental Health and Substance Abuse Managed Care Network (SOM Network)

BCN Products

☐ Commercial HMO
☐ BCN Advantage℠

Requested Termination Date*: _______________________
Reason for Termination: _______________________

*Please note that the actual date of your termination will be determined by the provisions in the applicable Participation Agreements.

Section 6: STAFFING CHANGES

State the name, phone number and email address of the following hospital officers/staff that have changed:

<table>
<thead>
<tr>
<th>Officer/Director</th>
<th>Name</th>
<th>Phone Number</th>
<th>E-Mail Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chief Operating Officer</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chief Executive Officer</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chief Financial Officer</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Director of Reimbursement</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Director of Utilization Management &amp; Quality Improvement</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical Director</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Medical Director License No.: ____________________________________________________________
Medical Director Credentials (MD, DO; Specialty)______________________________________

WP 13085 DEC 17
## Section 7: CHANGE IN BEDS IN USE/OPERATION, CLASSIFICATION

Indicate all changes to hospital’s beds in use and attach applicable State licensure supporting documentation:

<table>
<thead>
<tr>
<th>Change in the Number of Licensed Beds in Use/Operation, Classification</th>
<th>Addition</th>
<th>Deletion</th>
<th>Effective Date</th>
<th>License #, If Applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Care Beds</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Burn Unit Beds</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NICU Beds</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acute Rehabilitation Beds</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychiatric Care Beds</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychiatric Partial Beds</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## Section 8: ATTESTATION

I certify by my signature the following:

– The information contained in this Hospital Change Form is complete and accurate at the time of submission.

– Documentation regarding any of the information contained in this Hospital Change Form will be produced upon request.

– The hospital will make best efforts to notify BCBSM/BCN of any relevant changes that may occur that would alter the responses provided in this Hospital Change Form.

– The hospital will comply with any additional requests for information, documentation, or onsite reviews necessary to credential and/or recredential the site.

– BCBSM/BCN shall be held harmless from any claims, lawsuits, etc., that arise as a result of the misrepresentation of information provided in response to this Hospital Change Form.

– I understand and agree that if I am an applicant for BCN, I 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.

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

Signature: ___________________________ Date: ___________________________

Printed Name: ___________________________

Title: ___________________________ Phone Number: ___________________________

WP 13085 DEC 17
APPENDIX 1 – NETWORK DESCRIPTIONS

BCBSM

**Traditional**
Traditional participation as a short-term acute care hospital (hospital: a short-term intensive rehabilitation hospital), or a short-term acute psychiatric hospital with BCBSM is available on a formal basis. Services must meet the member's benefit criteria to be payable. Members of other Blue Cross Blue Shield (BCBS) Plans also use BCBSM's hospital networks, as applicable, when their members receive hospital services in Michigan. Therefore, member benefits, eligibility, and benefit requirements (for example, preauthorization) should always be verified before providing services. Covered services provided in a Traditional nonparticipating hospital are generally reimbursed to the member in accordance with the member's certificate of benefit plan.

**TRUST Network (PPO)**
To participate in the TRUST hospital network, a hospital must also be in the Traditional-Participating and meet additional qualification standards. The TRUST hospital network is for BCBSM members enrolled in PPO products (for example, Community Blue℠ PPO, Blue Preferred®, PPO, Blue Preferred Plus PPO, etc.) and members of other Blue Cross Blue Shield Plans that also use BCBSM's TRUST hospital networks. PPO members are typically subject to out-of-network cost sharing and/or benefit restrictions if hospital services are not delivered in a TRUST hospital. If the out-of-network hospital is also Traditional non-participating network, reimbursement for covered services is made to members, in accordance with their certificates or benefit plans.

**Medicare Advantage PPO**
Medicare certified hospitals are eligible to apply for participation in the BCBSM Medicare Advantage PPO network. To participate in the MA PPO network, hospitals must have and maintain all qualification requirements for TRUST hospital participation.

**Medicare Supplemental**
Patients who have primary coverage through Original Medicare may also have Medicare Supplemental coverage through BCBSM. This benefit, if available to the patient, may provide coverage for payment of applicable Medicare deductibles, copayments and/or for days of care in excess of those paid for by Medicare. In general, the effective date of a hospital's eligibility for payment under the BCBSM Medicare Supplemental program coincides with the effective date of the hospital's Medicare certification. This date may be different than the hospital's Traditional program participation effective date. All hospitals that are approved for participation in BCBSM's Traditional program are approved for Medicare Supplemental payments.

**BCBSM's Mental Health and Substance Abuse Managed Care Network (SOM Network)**
BCBSM's Mental Health and Substance Abuse Managed Care (MHSAMC) network is called the State of Michigan (SOM) Mental Health Network. It is utilized by select BCBSM customer groups that have chosen a managed care program for inpatient and outpatient mental health and substance abuse benefits. For hospitals, this network applies only to inpatient psychiatric and partial psychiatric care. Other benefits are delivered by other provider types (such as Substance Abuse facilities and Outpatient Psychiatric Care facilities). This network is currently used by UAW Retiree Medical Benefits Trust (URMBT) members, Chrysler members, Ford Hourly National PPO Plan members, and Ford Blue Preferred Plus members. This network is currently managed (care preauthorized) by a vendor care manager. Members are subject to out-of-network cost sharing and/or benefit restrictions. For some benefit plans, out-of-network referrals are not allowed and the member has no benefit when receiving services from an out-of-network hospital.

**Other Non-Acute BCBSM Provider Classifications**
Certain non-acute services that hospitals may provide must be separately contracted (and require separate facility codes) with BCBSM (for example, separately licensed Ambulatory Surgery Facilities even if CMS considers the ASF provider-based, Home Health Care services, Home Infusion Therapy, Hospice, Outpatient Psychiatric Care facilities, Skilled Nursing Facilities, Substance Abuse facilities, and Urgent Care Centers that are not physically attached to the hospital, etc.). Separate applications for these programs, as well as for Long-Term Acute Care Hospitals can also be found in the provider/enrollment section at bcbsm.com.
APPENDIX 1 – NETWORK DESCRIPTIONS (continued)

BCN

Commercial HMO
Blue Care Network offers a Commercial HMO network that includes physicians, hospitals and other medical professionals to provide state-of-the-art health care services for members. BCN offers its members health information, risk assessment tools and special programs to help reach their health and wellness goals.

BCN Advantage
BCN Advantage is Blue Care Network’s Medicare Advantage HMO product. BCN has contracted with the Centers for Medicare & Medicaid Services to provide health care services to Medicare beneficiaries. The BCN Advantage plan is designed to:

- Provide members with all Medicare-covered services
- Offer preventive and wellness care (for example, an annual physical exam) and encourage the Medicare population to use medical services for preventive care
- Limit member cost to a predetermined copayment for Medicare Advantage (Medicare Parts A + B) coverage

BCN, not Medicare, is the payer for covered health services rendered to a BCN Advantage member, with the exception of hospice care.