Instructions for fax cover sheet

We cannot accept handwritten forms. 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 NPI 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 to 866-900-0250.

Questions? Call 1-800-822-2761

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: 10592

Type 2 NPI:

Tax Identification Number:

Blue Cross Blue Shield Blue Care Network of Michigan

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

Hospital Change Form

	Type 2 National provider identifier	Tax identification number

If you are changing one or more of the following data elements, please complete the following section(s):

- Change hospital name, fiscal year end, operations or tax status - Section 1
- Change primary, payment/remit, mailing and/or medical records addresses, phone numbers or website - Section 2
- Change hospital designations, certifications or NPI - Section 3
- Request additional networks - Section 4
- Request to terminate networks - Section 5
- Change staffing information - Section 6
- Change in beds in use/operation, classification - Section 6

☐ **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 of change:_____ Ceasing Operations: _____

Effective Date of Closure: _____ Fiscal Year Ending Change*: _____

Fiscal Year End 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.

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Section 2: Address Change

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.

	Type 2 National provider identifier	Tax identification number

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:

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

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 PPO℠)
- ☐ 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-POS℠

	Type 2 National provider identifier	Tax identification number

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:

Officer/Director	Name	Phone Number	E-Mail Address
Chief Operating Officer			
Chief Executive Officer			
Chief Financial Officer			
Director of Reimbursement			
Director of Utilization Management & Quality Improvement			
Medical Director			

Medical Director License No.: _____

Medical Director Credentials (MD, DO; Specialty): _____

	Type 2 National provider identifier	Tax identification number

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:

Change in the Number of Licensed Beds in Use/Operation, Classification	Addition	Deletion	Effective Date	License #, If Applicable
Acute Care Beds				
Burn Unit Beds				
NICU Beds				
Acute Rehabilitation Beds				
Psychiatric Care Beds				
Psychiatric Partial Beds				

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: _____

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 or 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**.

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.