# Facility Enrollment Form

**PLEASE:**

1. **Complete the application in its entirety.**
2. **No handwritten forms, please type.**
3. **This coversheet must be the first page of your form submission.**
4. **Fax the enrollment form and attachments (i.e. supporting documents) to 1-855-306-9762 or email to bccproviderdata@mibluecrosscomplete.com. Be sure to submit the enrollment form separately for each provider. (For example: if you register two or more providers, you must send a fax/email for each provider. They cannot be bundled into one transmission.)**
5. **You can also mail the completed forms and documentation to: Blue Cross Complete of Michigan, Provider Network Management, 4000 Town Center; Suite 1300, Southfield MI 48075.**
6. **Based on your provider type, there are specific sections that must be completed. Please review the enrollment form in its entirety to ensure each required section is completed.**
7. **Supporting documents checklist is located at the end of the enrollment form, please review and ensure all required documents are submitted along with this enrollment form.**

| **To avoid processing delays, please ensure all fields below are completed** | | |
|---|---|---|
| **Fax to:** | **1-855-306-9762** Attn: Provider Network Management | |
| **Email to:** | **BCCproviderdata@mibluecrosscomplete.com** | |
| **From:** | | |
| **Date:** | | |
| **Type 2 NPI:** | | |
| **Tax identification number:** | | |
| **Is the provider enrolled in CHAMPS*?** | **Yes** ☐ **No** ☐<br>**If yes, Effective date:** **End date:** | |
| **Is the provider already enrolled with Blue Cross Blue Shield of Michigan or Blue Care Network?** | **Yes** ☐ **No** ☐ | |
| **If "No," you will be provided additional forms for completion and this may delay the enrollment process.** | | |

* Michigan Department of Health and Human Services enrollment system

# Facility Enrollment Form

| Type 2 NPI | Tax Identification Number |
|---|---|
| | |

## Section 1: Demographic data

*denotes a required field

| | |
|---|---|
| **1.** *Provider name | |
| **2.** *Provider type | ☐ Acute Care Hospital<br>☐ Ambulatory Infusion Center<br>☐ Ambulatory Surgical Facility<br>☐ Clinical Independent Laboratory<br>☐ Durable Medical Equipment Supplier<br>☐ End Stage Renal Disease Facility<br>☐ Freestanding Radiology Center<br>☐ Home Healthcare Facility<br>☐ Home Infusion Therapy<br>☐ Hospice<br>☐ Independent Diagnostic Testing Facility<br>☐ Long-term Acute Care Hospital<br>☐ Outpatient Physical Therapy Facility<br>☐ Outpatient Psychiatric Center<br>☐ Prosthetic and Orthotic Suppliers<br>☐ Rural Health Clinic<br>☐ Skilled Nursing Facility<br>☐ Urgent Care Center |
| **3.** *Tax identification number | |
| **4.** *Tax identification name (as filed with the IRS) | |
| **5.** *Tax exempt? | ☐ Yes ☐ No |
| **6.** *Providers website (URL address) | |
| **7.** *Associated NPI numbers | |
| **8.** State license number | |
| **9.** Medicaid number | |

# Facility Enrollment Form

| Type 2 NPI | Tax identification number |
|---|---|
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## Section 2: Address information – please make copies for additional addresses

| | |
|---|---|
| **1. Practice address** (must be an address where health care services are rendered and may be published in the Blue Cross Complete provider directory) | |
| a. *Street address | |
| b. *City | |
| c. *State | |
| d. *Zip code | |
| e. County | |
| f. *Primary telephone number | |
| g. Fax number | |
| **2. Payment or remit address (if different from your practice address)** | |
| a. Street address | |
| b. City | |
| c. State | |
| d. Zip code | |
| **3. Mailing address (if different from your practice address)** | |
| a. Street address | |
| b. City | |
| c. State | |
| d. Zip code | |
| **4. Medical records request (if different from your practice address)** | |
| a. Street address | |
| b. City | |
| c. State | |
| d. Zip code | |

# Facility Enrollment Form

| Type 2 NPI | Tax identification number |
|---|---|
| | |

## Section 3: Address information – Accessibility

* denotes required field

| | | |
|---|---|---|
| 1. *Handicap accessible | Yes ☐ | No ☐ |
| 2. *Accessible by train | Yes ☐ | No ☐ |
| 3. *Accessible by bus | Yes ☐ | No ☐ |

4. *ADA accessibility – please check all categories that indicate where your office is barrier free

| | | | | | | |
|---|---|---|---|---|---|---|
| Service Location ☐ | Restrooms ☐ | Medical Equipment ☐ | Exam rooms ☐ | Blind ☐ | Hard of hearing ☐ | Cognitively disabled ☐ |

5. ***Contact information –** please provide the name and contact information of a person who can answer questions about information in this enrollment form

| | |
|---|---|
| a. *Contact name | |
| b. *Telephone number | |
| c. *Email address | |

6. ***Office hours**

| | **From** | **To** |
|---|---|---|
| a. Monday | | |
| b. Tuesday | | |
| c. Wednesday | | |
| d. Thursday | | |
| e. Friday | | |
| f. Saturday | | |
| g. Sunday | | |

## Section 4: Medical Director information

* denotes required field

| | |
|---|---|
| 1. Medical Director name | |
| 2. Medical Director professional license number | |
| 3. Medical Director type 1 NPI | |

**4. Medical Director attestations**

I attest that all personnel practicing in the facility are appropriately licensed in Michigan.
I attest that during the prior five year period, there is an absence of fraud and illegal activities against the facility.

Medical Director signature:_____ Date:_____

# Facility Enrollment Form

| Type 2 NPI | Tax identification number |
|---|---|
| | |

## Section 5: Malpractice insurance information

| **1. Malpractice Insurance**<br>All hospitals must maintain a level of medical liability insurance limits of $1,000,000/$3,000,000 limits and general liability insurance limits of $1,000,000/$2,000,000. All other 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. | | |
|---|---|---|
| a. Current **medical** liability coverage | Occurrence | Per aggregate |
| b. Expiration date | | |
| c. Liability coverage is renewed | Annually ☐ | Continuous ☐ |
| d. Current **general** liability coverage | Occurrence | Per aggregate |
| e. Expiration date | | |
| f. Liability coverage is renewed | Annually ☐ | Continuous ☐ |
| g. Are physicians, practitioners and professional clinicians covered under the malpractice insurance? | Yes ☐ | No ☐ |
| h. Carrier name | | |
| i. Coverage amounts | Per occurrence | Per aggregate |

# Facility Enrollment Form

| Type 2 NPI | Tax identification number |
|---|---|
| | |

## Section 6 – Accreditation information

* denotes required field

If not accredited by one the below agencies, please provide a copy of your most recent Center for Medicare and Medicaid Services survey or a copy of the CMS letter showing your facility is in substantial compliance

| | |
|---|---|
| 1. Accredited by | ☐ Accreditations Association for Ambulatory Health Care<br>☐ Accreditation Commission for Health Care<br>☐ American College of Radiology<br>☐ American Osteopathic Association<br>☐ Continuing Care Accreditation Commission<br>☐ Community Health Accreditation Program Inc.<br>☐ Council of Accreditation<br>☐ Det Norske Veritas Healthcare<br>☐ Healthcare Facilities Accreditation Program<br>☐ Joint Commission on Accreditation of Healthcare Organizations<br>☐ Public Health Department<br>☐ Other: _____ |
| 2. Effective date | |
| 3. Expiration date | |

# Facility Enrollment Form

| Type 2 NPI | Tax identification number |
|---|---|
| | |

## Section 8 – Acute care hospital REQUIRED information

* denotes required field

Please attach an additional page if you have more inpatient campus addresses under the same tax ID and license as the primary or main campus. Be sure to include all requested information above (name, NPI and addresses).

| | | |
|---|---|---|
| 1. Does the hospital employ physicians? | Yes ☐ | No ☐ |
| 2. If yes, do the employed physicians bill under the same Tax ID as the hospital? | Yes ☐ | No ☐ |
| 3. If no, indicate the tax ID and associated NPI they use: | | |
| a. Tax ID | b. NPI | |
| | | |
| | | |
| | | |
| 4. Does the hospital use any other tax IDs to do business? | Yes ☐ | No ☐ |
| 5. If yes, please list the tax IDs and associated NPI numbers: | | |
| a. Tax ID | b. NPI | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| 6. Does the main inpatient campus have an active emergency room? | Yes ☐ | No ☐ |
| 7. Does the main inpatient campus offer urgent care services in a center that is physically attached? | Yes ☐ | No ☐ |
| 8. Is the hospital part of a larger health care organization? | Yes ☐ | No ☐ |
| 9. If yes, provide the name of the health care organization | | |

# Facility Enrollment Form

| Type 2 NPI | Tax identification number |
|---|---|
| | |

## Section 8 – Acute care hospital REQUIRED information – continued

* denotes required field

| | |
|---|---|
| 10. What is the hospital's relationship to this larger healthcare organization? | ☐ Affiliation<br>☐ Joint operating agreement<br>☐ Management contract<br>☐ Wholly owned subsidiary<br>☐ Other, please list_____ |

**List the following information for the hospital if it is owned by individuals. Attach additional pages if necessary**

| | |
|---|---|
| 11. Name: | |
| 12. Home address | |
| 13. Occupation | |
| 14. Ownership % | |
| 15. Name: | |
| 16. Home address | |
| 17. Occupation | |
| 18. Ownership % | |
| 19. Name: | |
| 20. Home address | |
| 21. Occupation | |
| 22. Ownership % | |

**Provide the following information for the hospital *if* an organization owns it or has managing control (e.g., corporation, governmental or tribal organizations, partnerships and limited partnerships, charitable or religious organizations). Attach additional pages if necessary.**

| | | | |
|---|---|---|---|
| 23. Organization name | | 24. Ownership % | |
| 25. Organization name | | 26. Ownership % | |
| 27. Organization name | | 28. Ownership % | |

# Facility Enrollment Form

| Type 2 NPI | Tax identification number |
|---|---|
| | |

## Section 8 – Acute care hospital REQUIRED information – continued

* denotes required field

| State the name, phone number and email address of the following hospital officers/staff | | | |
|---|---|---|---|
| **Officer/Director** | **Name** | **Phone number** | **E-mail address** |
| 29. Chief operating officer | | | |
| 30. Chief executive officer | | | |
| 31. Chief financial officer | | | |
| 32. Director of reimbursement | | | |
| 33. Director of utilization management & quality improvement | | | |
| 34. Medical director | | | |
| 35. Nursing director | | | |
| 36. Is the medical staff credentialed through an outside agency? | | Yes ☐ | No ☐ |
| 37. If yes, please provide the name of the Agency | | | |
| 38. Does the hospital have a governing or as an alternative, a community advisory board responsible to the governing board, which is legally responsible for the total operation of the hospital and for ensuring that quality care, is provided in a safe environment? | | Yes ☐ | No ☐ |
| 39. Does the governing or advisory board include persons representative of a cross section of the community? | | Yes ☐ | No ☐ |
| 40. Does the hospital have a graduate medical education program? | | Yes ☐ | No ☐ |
| 41. If yes, indicate the number of direct and/or indirect Full Time Equivalents for the hospital's GME program. | | Direct | Indirect |

# Facility Enrollment Form

| Type 2 NPI | Tax identification number |
|---|---|
| | |

## Section 8 – Acute care hospital REQUIRED information – continued

* denotes required field

| 42. Check all applicable Medicare and Medicaid designations/certifications that apply to the hospital | | | | |
|---|---|---|---|---|
| **Medicare designations /certifications** | **Yes** | **No** | **If Yes, CMS certification number** | **If Yes, CMS effective date (MM/DD/YYYY)** |
| a. Children's hospital (excluded from PPS) | ☐ | ☐ | | |
| b. Critical access hospital | ☐ | ☐ | | |
| c. Exempt psychiatric unit or psychiatric hospital (excluded from PPS) | ☐ | ☐ | | |
| d. Exempt rehabilitation unit or rehabilitation hospital (excluded from PPS) | ☐ | ☐ | | |
| e. Medicare dependent hospital | ☐ | ☐ | | |
| f. Rural referral center | ☐ | ☐ | | |
| g. Short-term (general and specialty) hospital | ☐ | ☐ | | |
| h. Sole community hospital | ☐ | ☐ | | |
| i. Swing beds | ☐ | ☐ | | |
| j. Hospital based – end stage renal dialysis | ☐ | ☐ | | |
| k. Other (specify) | ☐ | ☐ | | |

| 43. Have the hospital's licenses or any of the hospital's Medicare certifications ever been revoked, suspended or terminated for hospital services, or has the hospital or any of its owners ever been an excluded entity or an excluded individual from state or federal programs? | Yes ☐ No ☐ |
|---|---|

44. If yes, provide a complete explanation below: (attach additional pages if needed)

# Facility Enrollment Form

| Type 2 NPI | Tax Identification Number |
|---|---|
| | |

## Section 8 – Acute care hospital REQUIRED information – continued

* denotes required field

| | | | |
|---|---|---|---|
| 45. Does the hospital assess the quality of care rendered to patients to assure that proper services are provided at the proper time by qualified individuals? | Yes ☐ | | No ☐ |
| 46. Does the hospital identify, refer, report and follow up on quality of care issues and problems? | Yes ☐ | | No ☐ |
| 47. Does the hospital monitor all aspects of patient care delivery? | Yes ☐ | | No ☐ |
| 48. Does the hospital have beds allocated and staffed for a unit specifically designated for severe burn care? | Yes ☐ | # of beds in use/operation _____ | No ☐ |
| 49. Does the hospital have beds allocated and staffed for a unit specifically designated as a trauma unit? | Yes ☐ | # of beds in use/operation _____ | No ☐ |
| 50. Does the hospital have beds allocated and staffed for a unit specifically designated for Neonatal Intensive Care? | Yes ☐ | # of beds in use/operation _____ | No ☐ |
| 51. Does the hospital have beds allocated and staffed for a unit specifically designated as inpatient rehabilitation unit? | Yes ☐ | # of beds in use/operation _____ | No ☐ |
| 52. Does the hospital have beds allocated, staffed and licensed for a unit specifically designated for psychiatric care? | Yes ☐ | # of beds in use/operation _____ | No ☐ |

# Facility Enrollment Form

| Type 2 NPI | Tax identification number |
|---|---|
| | |

## Section 8 – Acute care hospital REQUIRED information – continued

* denotes required field

| 53. Please check the inpatient specialty the hospital is recognized for: | | | |
|---|---|---|---|
| Acute care | ☐ | Rehabilitation hospital/unit | ☐ |
| Surgical hospital | ☐ | Children's hospital | ☐ |
| Bariatric hospital | ☐ | Cancer hospital | ☐ |
| Psychiatric hospital/unit | ☐ | Partial psychiatric hospital | ☐ |
| Veteran | ☐ | Other | ☐ |

| | | |
|---|---|---|
| 54. Does the hospital maintain records of transactions that conform to generally accepted accounting principles? | Yes ☐ | No ☐ |
| 55. Are billing charges uniformly applied? That is, for identical services is the charge the same for all Patients? | Yes ☐ | No ☐ |
| a. If no, provide explanation: | | |
| 56. In the past five years, has the hospital filed a petition for relief under the U.S. Bankruptcy Code, or has any action been taken to dissolve, liquidate, terminate, consolidate, merge or sell all or substantially all of the hospital's assets? | Yes ☐ | No ☐ |
| a. If yes, provide explanation: | | |

# Facility Enrollment Form

| Type 2 NPI | Tax identification number |
|---|---|
| | |

## Section 8 – Acute care hospital REQUIRED information – continued

* denotes required field

| | |
|---|---|
| 57. Does the hospital have management contracts with an outside organization for the provision of core services (e.g., administrative services, staffing services, personnel management)? | Yes ☐ No ☐ |
| 58. If "Yes," please provide the name of the organization and describe the services provided by this outside organization in the space provided below. Blue Cross Complete may request a copy of the management contract at a later date. | |
| | |

# Facility Enrollment Form

| Type 2 NPI | Tax identification number |
|---|---|
| | |

## Section 9 – Enrollment signature

* denotes required field

I certify that:

- 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.
- I understand that Blue Cross Complete may do an on-site survey after review of this application to verify program compliance and the accuracy of any information provided.
- Written criteria for participation of medical staff exist for this facility.
- All employed and contracted health care professionals maintain current Michigan licenses or certifications as required for their positions. All staff members are licensed or certified as required for their positions.
- The facility maintains financial records that conform to generally accepted accounting principles and practices.
- All policies and procedures are implemented and enforced by this facility.
- The facility will comply with any requests for information, documentation or on site review reviews necessary to credential the site.
- The facility conducts program evaluation and utilization review to assess the appropriateness and effectiveness of its programs.
- I understand the effective date of participation is the date the application is actually approved by Blue Cross Complete and is not the date the application was submitted or received.
- I understand the facility is not eligible to submit claims for payment until it is approved by Blue Cross Complete, both parties sign the agreements and the processing systems are updated.
- I understand Blue Cross Complete's payment rates and the terms of its standard participation agreement are not negotiable.
- Blue Cross Complete shall be held harmless for any claims and lawsuits that arise as a result of the misrepresentation of information provided in response to this application.
- Neither the facility nor its managing employees, officers, directors, or major shareholders or owners (i.e. person with beneficial ownership of 5 percent or more) appear in Social Security Administration's *Death Master* File; the *National Plan and Provider Enumeration* System; the *Medicare Exclusion Database*; the Michigan Department of Health and Human Services /Medical Services Administration, *Sanctioned Provider* List; the Licensing and Regulatory Affairs *Disciplinary Action Report*; and any other database as the secretary of HHS may prescribe. Nor has facility, its managing employees, offices, directors, partners, agents, or major shareholders or 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 or owners (i.e. person with beneficial ownership of 5% or more) on matters relating to payments from governmental entities, both federal and state, for health care or prescription drug services. Additionally, neither facility nor its managing employees, officers, directors, major shareholders or 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.

# Facility Enrollment Form

**Credentialing – Healthcare professional and provider rights**

I understand that healthcare professional and providers have the right to:

- Review information obtained through primary source verification for credentialing purposes. This includes information from malpractice insurance carriers and state licensing boards. This does not include information collected from references, recommendations and other peer review protected information
- Be notified if any credential information is received that varies substantially from application information submitted by the health care professional or provider: (actions on license, malpractice claim history, suspension or termination of hospital privileges, or board-certification decisions with the exception of reference, recommendations or other peer-review protected information. The health care professional or provider will have the right to correct erroneous information if the credentialing information received varies substantially from the information that was submitted on his or her application
- Upon request, be informed of the status of their application – if application is current and complete, the applicant can be informed of the tentative date that his or her application will be presented to the Credentialing Committee for approval.

| *Print or type name | *Practitioner signature/title | *Date |
|---|---|---|
| | | |

# Facility Enrollment Form

**Facility enrollment required document checklist**

| Facility classification | To avoid processing delays, please ensure all items are submitted |
|---|---|
| Acute care hospital | • Copy of hospitals acute care license (if applicable)<br>• Copy of psychiatric inpatient hospital license (if applicable)<br>• Copy of psychiatric partial hospitalization license (if applicable)<br>• Copy of IRS-generated EIN notification number tax form (Form 147C or SS4).<br>• IRS document authorizing non-profit or tax-exempt status (if applicable)<br>• Hospital organizational chart<br>• Healthcare system's operating structure or organizational chart showing where the hospital falls within the organization (if applicable)<br>• Copy of face Sheet or declaration sheet of current professional and general liability Insurance<br>• Copy of most current accreditation certificates<br>• If not accredited, enclose a copy of the most recent state survey, or a letter from the state indicating Medicare certification based upon the state of Michigan survey.<br>• Most current Medicare provider number Letters (e.g., acute care, psych, rehab, ESRD)<br>• Registration and certificate or inspection information for mammography, X-ray machines & all other ionizing equipment<br>• CLIA certificate |
| Ambulatory infusion center | • Primary practice location in Michigan<br>• Type 2 National Provider Identifier<br>• Identified owner of Facility<br>• Internal Revenue Service document identifying tax ID number and associated payee name |
| Ambulatory surgical facility | • Primary practice location in Michigan<br>• Type 2 National Provider Identifier (NPI)<br>• Identified owner of Facility<br>• Internal Revenue Service document identifying tax ID number and associated payee name |
| Clinical independent laboratory | • Type 2 National Provider Identifier<br>• Internal Revenue Service document identifying tax ID number and associated payee name |
| Durable medical equipment supplier | • Type 2 National Provider Identifier<br>• Internal Revenue Service document identifying tax ID number and associated payee |

# Facility Enrollment Form

| Facility classification | To avoid processing delays, please ensure all items are submitted |
|---|---|
| End stage renal disease | • Primary practice location in Michigan<br>• Type 2 National Provider Identifier<br>• Identified owner of Facility<br>• Internal Revenue Service document identifying tax ID number and associated payee name |
| Freestanding radiology center | • Primary practice location in Michigan<br>• Type 2 National Provider Identifier<br>• Identified owner of facility<br>• Internal Revenue Service document identifying tax ID number and associated payee name |
| Home health care facility | • Type 2 National Provider Identifier (NPI)<br>• Identified owner of facility<br>• Internal Revenue Service document identifying tax ID number and associated payee name |
| Home infusion therapy | • Primary practice location in Michigan<br>• Type 2 National Provider Identifier<br>• Identified owner of facility<br>• Internal Revenue Service document identifying tax ID number and associated payee name |
| Hospice | • Primary practice location in Michigan<br>• Type 2 National Provider Identifier<br>• Identified owner of Facility<br>• Internal Revenue Service document identifying Tax ID number and associated payee name |
| Independent diagnostic testing facility | • Type 2 National Provider Identifier<br>• Internal Revenue Service document identifying Tax ID number and associated payee name |
| Outpatient Physical Therapy Facility | • Primary practice location in Michigan<br>• Type 2 National Provider Identifier<br>• Identified owner of facility<br>• Internal Revenue Service document identifying tax ID number and associated payee name |

# Facility Enrollment Form

| Facility classification | To avoid processing delays, please ensure all items are submitted |
|---|---|
| Outpatient Psychiatric Center | • Primary practice location in Michigan<br>• Type 2 National Provider Identifier<br>• Identified owner of facility<br>• Internal Revenue Service document identifying tax ID number and associated payee name |
| Prosthetic and Orthotic Suppliers | • Type 1 National Provider Identifier (for individually certified suppliers)<br>• Type 2 National Provider Identifier (for organizationally certified suppliers)<br>• Social security number (for individually certified suppliers)<br>• Internal Revenue Service document identifying tax ID number and associated payee name |
| Rural Health Clinic | • Primary practice location in Michigan<br>• Type 2 National Provider Identifier<br>• Identified owner of facility<br>• Internal Revenue Service document identifying tax ID number and associated payee name |
| Skilled Nursing Facility | • Primary practice location in Michigan<br>• Type 2 National Provider Identifier<br>• Identified owner of facility<br>• Internal Revenue Service document identifying tax ID number and associated payee name |
| Urgent Care Center | • Type 2 National Provider Identifier<br>• Internal Revenue Service document identifying tax ID number and associated payee name |