Practitioner Enrollment Form

Suite 1300
4000 Town Center
Southfield, MI 48075

mibluecrosscomplete.com

1. **Complete the application in its entirety.**
2. **No handwritten forms; please type.**
3. **This cover sheet 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 Operations, 4000 Town Center; Suite 1300, Southfield, MI 48075**
6. **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.**

Note: You are required to complete and maintain a credentialing application through the Council for Affordable Quality Healthcare® at https://upd.caqh.org/oas/.* In order for your Blue Cross Complete affiliation request to be processed, you **must complete your CAQH application** within 14 calendar days. If you have already completed the CAQH application, your attestation must be up to date. If your CAQH application is not complete or if your attestation is expired after 14 calendar days, your request will be closed and you will need to reapply once updated.

To avoid processing delays, please ensure all fields below are completed	
Fax to:	**1-855-306-9762** Attn: Provider Network Operations
Email to:	**BCCproviderdata@mibluecrosscomplete.com**
From:	
Date:	
Type 1 NPI:	
Type 2 NPI:	
State License Number:	
Is the provider enrolled in CHAMPS?**	**Yes** ☐ **No** ☐ **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", to either question, please be advised your application will be closed with no further action taken.	

*Blue Cross Complete does not control this website and is not responsible for its content

** Michigan Department of Health and Human Services enrollment system

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State license number	Type 1 NPI	Type 2 NPI

Section 1: Demographic information

* denotes required field

1. *First name		2. *Last name	
3. Middle name		4. *Degree or title	
5. Gender	Please select one	6. CAQH ID number	
7. *Date of birth (MM/DD/YYYY)		8. Ethnicity	
9. Social Security Number		10. Race	
11. Other names you may have used (Maiden, a.k.a., etc.)		12. Languages spoken other than English	
13. *Medicaid number		14. *Medicare number	

Section 2: Practice specialty for which you are seeking affiliation

1. *Provider type	Primary Care Practitioner ☐	Specialist ☐
2. *Specialty		
3. *Board certified (M.D., D.O., D.M.D., D.P.M., D.D.S. only)	Yes ☐	No ☐
4. *Board eligible (M.D., D.O., D.M.D., D.P.M., D.D.S. only)	Yes ☐	No ☐
5. Do you practice exclusively in a hospital setting? (if "Yes", Section 1 of the CAQH must be updated to reflect hospital based status)	Yes ☐	No ☐
6. Are you enrolling under a FQHC/RHC/THC/LHD group?	Yes ☐	No ☐

Section 3: Practice training information

1. **Provider Training** – Check all completed trainings					
Deafness or hard of hearing ☐	Serious Mental illness ☐	Child welfare ☐	Substance abuse ☐	Blindness or visual impairment ☐	Co-occurring disorders
Chronic Illness ☐	HIV/AIDS ☐	Physical disabilities ☐	Trauma ☐	Homelessness ☐	Cognitive disabled
LGBTQ+ ☐					

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Section 4: Advanced Practice Provider and Allied Health Practitioner supervising physicians

* denotes required field

1. Supervising physician name	
2. Supervising physician specialty	
3. Supervising physician NPI	

Section 5: Medical Care Group or Independent Physician Association Affiliation

* denotes required field

1. Please provide the name and ID of the medical care group, independent physician association or provider organization you are affiliated through (required for PCPs)	
a. Provider Organization name	
b. Provider Organization number (typically begins with an "IH")	

Section 6: Primary office practice information

* denotes required field

1. Primary office address (must be an address where health care services are rendered and may be published in the Blue Cross Complete provider directory, Primary Care Practitioners must practice a minimum of 20 hours per week, per location)	
a. *Group practice name (as it appears on W-9/SS4 form)	
b. *Federal tax ID	
c. *Tax exempt	☐ Yes ☐ No
d. *Street address	
e. *City	
f. *State	
g. *Zip code	
h. *County	
i. *Primary telephone number	
j. *Fax number	

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Section 6: Primary office practice information (continued)

* denotes required field

2. Payment or remit Address (if different from your primary address)	
a. Street address	
b. City	
c. State	
d. Zip code	
3. Mailing address (if different from your primary address)	
a. Street address	
b. City	
c. State	
d. Zip code	
4. Medical Records Request (MMR) (if different from your primary address)	
1. Street address	
2. City	
3. State	
4. Zip Code	

5. *Office hours		
	From	**To**
a. Monday		
b. Tuesday		
c. Wednesday		
d. Thursday		
e. Friday		
f. Saturday		
g. Sunday		

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State license number	Type 1 NPI	Type 2 NPI

Section 6: Primary office practice information (continued)

* denotes required field

6. Waiting times (in days)	
a. Routine visits	
b. Well exams	
c. Urgent problems	
d. Preventative care	
e. Emergency care	
f. Specialty care	
g. Acute specialty care	
h. Prenatal (first or second trimester)	
i. Prenatal (third trimester)	
j. High risk	
7. Panel information	
a. Do you place an age limit on your patients?	Minimum age: _____ Maximum age: _____
b. Accepting new patients into the practice?	☐ Yes ☐ No
c. Accepting existing patients only?	☐ Yes ☐ No
d. Place limitation on patient gender?	☐ Male ☐ Female

8. *ADA accessibility – Check all categories that indicate where your office is barrier free

Service Location ☐	Restrooms ☐	Exam rooms ☐	Medical Equip ☐	Blind ☐	Cognitively disabled ☐	Hard of hearing ☐

9. Vaccines for Children Program	
a. Do you participate in the Vaccines for Children Program?	☐ Yes ☐ No

10. 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	
d. *Provider website (URL address)	

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Section 7: Secondary office practice information

* denotes required field

1. Secondary office address (must be an address where health care services are rendered and may be published in the Blue Cross Complete provider directory)			
a. *Group practice name (as it appears on W-9 /SS4 form)			
b. *Federal tax ID		c. Type 2 NPI (if different)	
d. *Tax exempt	☐ Yes	☐ No	
e. *Street address			
f. *City			
g. *State			
h. *Zip code			
i. County			
j. *Primary telephone number			
k. Fax number			
2. Payment or remit address (if different from your secondary address)			
a. Street address			
b. City			
c. State			
d. Zip code			
3. Mailing address (if different from your secondary address)			
a. Street address			
b. City			
c. State			
d. Zip code			
4. Medical Records Request (MMR) (if different from your secondary address)			
a. Street address			
b. City			
c. State			
d. Zip code			

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State license number	Type 1 NPI	Type 2 NPI

Section 7: Secondary office practice information - continued

* denotes required field

5. *Office hours		
	From	**To**
a. Monday		
b. Tuesday		
c. Wednesday		
d. Thursday		
e. Friday		
f. Saturday		
g. Sunday		

6. Waiting times (in days)	
a. Routine visits	
b. Well exams	
c. Urgent problems	
d. Preventative care	
e. Emergency care	
f. Specialty care	
g. Acute specialty care	
h. Prenatal (first or second trimester)	
i. Prenatal (third trimester)	
j. High risk	

7. Panel information		
a. Do you place an age limit on your patients?	Minimum age: _____	Maximum age: _____
b. Accepting new patients into the practice?	☐ Yes	☐ No
c. Accepting existing patients only?	☐ Yes	☐ No
d. Place limitation on patient gender?	☐ Male	☐ Female

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8. *ADA accessibility – Check all categories that indicate where your office is barrier free						
Service Location ☐	Restrooms ☐	Exam rooms ☐	Medical Equip ☐	Blind ☐	Cognitively disabled ☐	Hard of hearing ☐

9. Vaccines for Children Program		
a. Do you participate in the Vaccines for Children Program?	☐ Yes	☐ No

Section 8: Services

1. Telehealth		
a. Do you offer services	☐ Yes	☐ No
b. If yes, though what do you offer these services? ***Please check all that apply***	☐ Video ☐ Provider mobile app ☐ Internet (website)	☐ Phone
c. Is this technology HIPAA compliant?	☐ Yes	☐ No

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Section 9: Compliance Attestation – Primary Care Providers

1. Children Special Health Care Services and/or Transition-aged youth or young adults with chronic health conditions
If you'd like to provide services to the Blue Cross Complete CSHCS population and meet the primary care practice criteria listed below, please check one or both boxes that apply:

A. Provider currently serves special populations of:
☐ Children or youth with complex chronic health conditions
☐ Transition-aged youth or young adults with complex chronic health conditions.

B. Provider's practice has a procedure in place to identify special populations of children, youth, transition-aged youth or young adults with chronic health conditions.

C. Provider's practice will provide expanded appointments when the special populations of children, youth, transition-aged youth or young adults have complex needs and requires more time.

D. Provider's practice has experience coordinating care for special populations of children, youth, transition-aged youth or young adults who receive services from multiple professionals, such as subspecialists, physical therapists and behavioral health professionals, etc.

E. Provider's practice has a designated professional responsible for care coordination for children, youth or young adults who see multiple professionals.

F. Provider's practice is open to new patients (children, youth, transition-aged youth or young adults) with potentially complex chronic health conditions.

G. Provider's practice provides services that are appropriate Health Care Transition, including the use of a transition readiness assessment and adoption of a transition policy that is publicly posted and specifies:

1. The transition time frame
2. The transition approach
3. Any legal changes that take place in privacy and consent at age 18

H. Provider will notify Blue Cross Complete should the provider no longer be able to meet the requirements outlined above.

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Section 10: Enrollment signature

* denotes required field

I certify that the information contained in this application is true and complete and the accompanying documents are correct and complete to the best of my knowledge and belief. If this enrollment form contains any material omission or false or misleading information, I understand that participation with Blue Cross Complete may be rejected or terminated. I further understand that a copy of these statements shall be as binding as the original.

I will notify Blue Cross Complete of Michigan immediately in writing of changes affecting this data. If I am a practitioner in training, I will not report services that are related to my training program and rendered at the address from which I am training. Should I re-enter training, I will notify Blue Cross Complete of Michigan.

I hereby authorize Blue Cross Complete to verify the information provided on this application and accompanying documentation through contracting, credentialing, recredentialing or reappointment activity of Blue Cross Complete.

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 and title	*Date

Provider enrollment required document checklist

Provider classification	To avoid processing delays, please ensure all items are submitted
Anesthesia assistant	• Type 1 National Provider Identifier • W9 form • Supervising physician
Audiologist	• Type 1 National Provider Identifier • W9 form • State of Michigan professional license number • Council for Affordable Quality Healthcare number (if available)

Certified nurse midwife	• Type 1 National Provider Identifier
	• W9 form
	• State of Michigan professional license number
	• Council for Affordable Quality Healthcare number (if available)
	• For CNMs performing deliveries, the following are also required:
	  • Written confirmation of established privileges with hospitals or has hospital-affiliated birthing center
	  • Written confirmation of an established, interdependent relationship for medical consultation or collaboration or referral to an OB/GYN

Certified nurse practitioner	• Type 1 National Provider Identifier • W9 form • State of Michigan professional license number • Council for Affordable Quality Healthcare number
Certified registered nurse anesthetist	• State of Michigan professional license • Type 1 National Provider Identifier • W9 form • Council for Affordable Quality Healthcare number
Chiropractor	• Type 1 National Provider Identifier • W9 form • State of Michigan professional license number • Council for Affordable Quality Healthcare number

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Provider classification	To avoid processing delays, please ensure all items are submitted
Certified nurse specialist	• Type 1 National Provider Identifier • W9 form • State of Michigan professional license number • Council for Affordable Quality Healthcare number
Doctor of medicine	• Type 1 National Provider Identifier • W9 form • State of Michigan professional license number • Council for Affordable Quality Healthcare number
Hearing aid dealer	• Type 1 National Provider Identifier • W9 form • State of Michigan professional license number • Council for Affordable Quality Healthcare number (if available)
Independent occupational or physical therapist	• Type 1 National Provider Identifier • W9 form • State of Michigan professional license number • Council for Affordable Quality Healthcare number (if available)
Independent speech language pathologist	• Type 1 National Provider Identifier • W9 form • State of Michigan professional license number • Council for Affordable Quality Healthcare number (if available)
Licensed Master of social worker	• Type 1 National Provider Identifier • W9 form • State of Michigan professional license number • Council for Affordable Quality Healthcare number (if available)

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Provider classification	To avoid processing delays, please ensure all items are submitted
Licensed professional counselor	• Type 1 National Provider Identifier • State of Michigan professional license • W9 form • Council for Affordable Quality Healthcare number (if available)
Ophthalmologist	• Type 1 National Provider Identifier • W9 form • State of Michigan professional license number • Council for Affordable Quality Healthcare number (if available)
Optician or optical Supplier	• Type 2 National Provider Identifier • W9 form
Optometrist	• Type 1 National Provider Identifier • W9 form • State of Michigan professional license number • Council for Affordable Quality Healthcare number (if available)
Oral surgeon	• Type 1 National Provider Identifier • W9 form • State of Michigan professional license number • Council for Affordable Quality Healthcare number (if available)
Physician assistant	• Type 1 National Provider Identifier • W9 form • State of Michigan professional license number • Council for Affordable Quality Healthcare number (if available) • Supervising physician name and NPI

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Provider classification	To avoid processing delays, please ensure all items are submitted
Podiatrist	• Type 1 National Provider Identifier • W9 form • State of Michigan professional license number • Council for Affordable Quality Healthcare number
Psychiatrist	• Type 1 National Provider Identifier • W9 form • State of Michigan professional license number • Council for Affordable Quality Healthcare number
Psychologist	• Type 1 National Provider Identifier • W9 form • State of Michigan professional license number • Council for Affordable Quality Healthcare number (if available)