Recuperative Care 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 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.**
7. **Ensure the organization is enrolled with Michigan Department of Health and Human Services Community Health Automated Medicaid Processing (CHAMPS) system.**
8. **Ensure the organization meets the National Institute for Medical Respite Care (NIMRC) standards for medical respite care programs (https://nimrc.org/standards-for-medical-respite-programs/)**

Fax to:	**1-855-306-9762** Attn: Provider Network Operations
Email to:	BCCproviderdata@mibluecrosscomplete.com
From:	
Date:	
Type 2 (organizational) NPI:	
Tax identification number:	

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Type 2 NPI	Tax Identification Number

Section 1: Demographic data

*denotes a required field.

1. *Organization Name	
2. *Tax identification number	
3. *Tax identification name (as filed with the IRS)	
4. Website (URL address)	
5. State license number	
6. Medicaid number	

Section 2: Address information

* denotes required field.

1. Business address (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. Email	
h. Areas Served (County/Counties Served)	
i. * # of RC beds	
2. Payment or remit address (if different from your business address)	
a. Street address	
b. City	
c. State	
d. Zip code	

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3. Mailing address (if different from your business address)	
a. Street address	
b. City	
c. State	
d. Zip code	

Section 3: Contact Information

*denotes a required field.

1. **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	

Section 4: Insurance information

*denotes a required field.

1. Insurance Provider must maintain: a level of professional liability coverage with minimum limits of $100,000 per incident, $500,000 annual aggregate, and separate general liability coverage in amounts commensurate with applicable industry standards. ***Please provide copies of fact sheets.***		
a. * Current commercial general liability coverage	Occurrence	Per aggregate
b. * Expiration date		
c. * Liability coverage is renewed	Annually ☐	Continuous ☐
d. * Carrier name		

Type 2 NPI	Tax Identification Number

Section 5 – Enrollment signature

* denotes required field.

I certify that:

- All required certificates and licenses are current and valid.
- 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.
- 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 provider maintains financial records that conform to generally accepted accounting principles and practices.
- All policies and procedures are implemented and enforced by provider.
- The provider will comply with any requests for information, documentation, or on-site review reviews necessary to credential the site.
- The provider 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 approved by Blue Cross Complete and is not the date the application was submitted or received.
- I understand the provider 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 Completes 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 because of the misrepresentation of information provided in response to this application.
- Neither the provider 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 the provider 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 the provider 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.

*Print or type name	* Signature/title	*Date

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Recuperative Care enrollment required document checklist

Provider classification	To avoid processing delays, please ensure all items are submitted
Recuperative Care	• Professional and Commercial General Liability insurance • Copy of the National Institute for Medical Respite Care standards attestation form (BPHASA-2428) form • Type 2 (organizational) National Provider Identifier • Internal Revenue Service document identifying tax ID number and associated payee name