Blue Cross Blue Shield Blue Care Network of Michigan

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

CREDENTIALING AND RECREDENTIALING FACILITY AND ALLIED PROVIDER

Type 2 National provider identifier	Tax Identification number

Please complete this form for recredentialing and/or credentialing new location(s).

Section 1: Demographic Data

*denotes a required field

*Provider name

*What type of Facility or Allied Provider are you? (Select 1 per application)

- ☐ Acute Care Hospital
- ☐ Ambulatory Infusion Center
- ☐ Ambulatory Surgery Facility
- ☐ Clinical Independent Laboratory
- ☐ Critical Access Hospital
- ☐ Durable Medical Equipment
- ☐ End-Stage Renal Disease
- ☐ Federally Qualified Health Center
- ☐ Freestanding Radiology Center
- ☐ Halfway House
- ☐ Home Health Care
- ☐ Home Infusion Therapy
- ☐ Hospice
- ☐ Long-Term Acute Care Hospital
- ☐ Outpatient Physical Therapy Facility
- ☐ Outpatient Psychiatric Care Facility
- ☐ Private Duty Nursing
- ☐ Psychiatric Hospital
- ☐ Psychiatric Residential Treatment Facility
- ☐ Rehabilitation Hospital
- ☐ Retail Health Center
- ☐ Rural Health Clinic
- ☐ Skilled Nursing Facility
- ☐ Substance Abuse Facility
- ☐ Urgent Care Center

Are you open for business?

Yes ☐ Date Opened? _____

No ☐ Date to Open for business? _____

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Section 1A: Demographic Data for Substance Abuse Specialty and Services

*denotes a required field

*Facility type Substance Abuse must indicate detoxification/withdrawal management services provided, by checking the appropriate box(es) below.

***Substance Abuse Facility**

Check the box to identify the type of programs offered. Appropriate Michigan licensure is required for all programs/services provided:

☐ Ambulatory

☐ Residential (Is a Registered Nurse on-site 24-hours for detoxification/withdrawal services?) ☐ Yes ☐ No

☐ Inpatient (Is a Registered Nurse on-site 24-hours for detoxification/withdrawal services?) ☐ Yes ☐ No

☐ Methadone Treatment (also requires proof of DEA license to be attached)

Is the facility a Government Entity? ☐ Yes ☐ No *(if Yes, attach copy of letter)*

Section 2: Accreditation

*denotes a required field

*Is this provider accredited? (Attach copy) ☐ Yes ☐ No

If yes, complete the following:

*Date of accreditation (mm/dd/yyyy)	*Expiration date of accreditation (mm/dd/yyyy)

*Name of accrediting body

*Type of accreditation or accreditation program (e.g. hospital accreditation program, home health accreditation, etc.)

Comments (use this section for comments related to the accreditation status)

*If **not accredited**, please provide a copy of your most recent CMS survey or a copy of the CMS Letter showing that your facility is in compliance.

*Federally Qualified Health Center and Rural Health Clinic – Include a copy Initial CMS Certification Letter or Health Resources Service Administration (HRSA) letter showing the grant coverage period.

CREDENTIALING AND RECREDENTIALING FACILITY AND ALLIED PROVIDER

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Section 3: Professional ID's

Provider type / documentation required	Professional ID number
Ambulatory Infusion Center *Michigan Pharmacy License *(attach copy)*	
Ambulatory Surgery Facility *Facility State License *(attach copy)*	
Clinical Independent Laboratory *CLIA Certificate *(attach copy)* *Registration and certificate/inspection information for mammography, x-ray machines & all other ionizing equipment *(attach copy)*	
Freestanding Radiology Center *Certificate of Need for PET, MRI or Megavoltage Radiation Therapy *(attach copy)* *Registration and certificate/inspection information for mammography, x-ray machines and all other ionizing equipment *(attach copy)*	
Home Infusion Therapy *Michigan Pharmacy License *(attach copy)*	
Hospice *Facility State License *(attach copy)*	
Hospital *CLIA Certificate (attach copy) Is the hospital state owned? Yes No *(If Yes, attach a copy of government entity letter)*	
Psychiatric Residential Treatment Facility *Facility State License *(attach copy)*	
Skilled Nursing Facility *Facility State License *(attach copy)*	
Substance Abuse Facility *Is substance abuse facility state owned? Yes No **(If Yes, attach a copy of government entity letter)*	
Urgent Care *Facility State License if Hospital Owned (attach copy) *Registration and certificate/inspection information for any ionizing equipment if on location *(attach copy)*	
Medicaid Number	

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Section 4: Medical/Clinical/Nursing/Physician Assistant Director

*denotes a required field

This section is required for all organizational and facility provider types except Clinical Independent Laboratories and Durable Medical Equipment.

*Medical Director Name	*Medical Director Michigan Professional License #
*Medical Director credentials (MD, DO, Specialty)	*Medical Director Type 1 NPI
Outpatient Physical Therapy Facility *Clinical Director Name	*Clinical Director Michigan Professional License #
*Clinical Director credentials (Physical, Occupational or Speech Therapist Overseeing)	*Clinic Director Type 1 NPI
Private Duty Nursing *Medical or Nursing Director Name	*Medical or Nursing Director Michigan Professional License #
*Medical (MD, DO) Nursing (RN or CNP) Director credentials	*Medical or Nursing Director Type 1 NPI
Retail Health Center *Medical Director, Nurse Practitioner or Physician Assistant Overseeing Name	*Medical Director, Nurse Practitioner or Physician Assistant Michigan Professional License #
*Medical (MD,DO) Director or Nurse Practitioner/Physician Assistant Overseeing Credentials	*Medical Director, Nurse Practitioner or Physician Assistant Type 1 NPI

*Medical Director, Clinical Director, Medical/Nursing Director and Nurse Practitioner/Physician Assistant Attestations

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

*Signature: _____ *Date: _____

Staffing *Required

*Are the medical staff credentialed through an: ☐ Internal Process ☐ Outside Agency

*If an outside agency is used, please provide the agency's name: _____

Type 2 National provider identifier	Tax Identification number

Section 5: Professional and General Liability Insurance

*denotes a required field

Hospitals must maintain a level of professional liability insurance of $1,000,000/$3,000,000 limits and general liability insurance in the amount of $1,000,000/$2,000,000. Please provide copies of both policy face sheets.

Facilities must maintain a level of professional 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.

All Allied Organizational Providers must maintain a level of professional liability insurance in the amount of $500,000/ $1,000,000 and general liability insurance in the amount of $1,000,000/$2,000,000. Please provide copies of both policy face sheets.

*Current **General** Liability Coverage (occurrence) _____ (per aggregate) _____
*Expiration date: _____ *Liability Coverage is renewed: ☐ Annually ☐ Continuous
*Current **Professional** Liability Coverage (occurrence) _____ (per aggregate) _____
*Expiration date: _____ *Liability Coverage is renewed: ☐ Annually ☐ Continuous
*Are physicians, practitioners and professional clinicians covered under the professional liability insurance: ☐ Yes ☐ No
*Carrier Name

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Section 6A: Primary Address

*denotes a required field

Primary address (must be a **physical** address where health care services are rendered and may be published in BCBSM / BCN provider directories. Primary address cannot be a P.O. Box.)

Has the primary office address changed: ☐ Yes ☐ No

If Yes; effective date _____

*Street Address		*Suite #
*City	*State	*Zip Code

Primary Telephone Number must be a phone number patients can call to make an appointment.

*Primary Telephone Number	Extension	Fax Number

Primary address - Contact Information

Credentialing Contact information

Please provide the name and contact information of a person who can answer questions about information in this application.

*First name		*Last name
*Telephone Number	Extension	Fax number
*Email Address		

Primary address - Accessibility

***Handicap accessibility:** ☐ Yes ☐ No ***Accessible by bus:** ☐ Yes ☐ No

Primary Address - Office Hours

Office Hours	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Open Time							
Close Time							

Do you provide 24/7 coverage at this location? ☐ Yes ☐ No

Type 2 National provider identifier	Tax Identification number

Section 6B: Add additional location

*denotes a required field

2 **Additional address** (must be a **physical** address where health care services are rendered and may be published in BCBSM / BCN provider directories. Primary address cannot be a P.O. Box.)

Has the additional office address changed? ☐ Yes ☐ No

If Yes, effective date _____

*Street Address		*Suite #
*City	*State	*Zip Code

Telephone number must be a phone number patients can call to make an appointment.

*Primary Telephone Number	Extension	Fax Number

Additional address - Contact Information

Credentialing Contact information

Please provide the name and contact information of a person who can answer questions about information in this application.

*First name	*Last name

*Telephone Number	Extension	Fax number

*Email Address

Additional address - Accessibility

***Handicap accessibility:** ☐ Yes ☐ No ***Accessible by bus:** ☐ Yes ☐ No

Additional address - Office Hours

Office Hours	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Open Time							
Close Time							

Do you provide 24/7 coverage at this location? ☐ Yes ☐ No

Type 2 National provider identifier	Tax Identification number

Section 6B: Add additional location *(continued)*

*denotes a required field

3 **Additional address** (must be a **physical** address where health care services are rendered and may be published in BCBSM / BCN provider directories. Primary address cannot be a P.O. Box.)

Has the additional office address changed? ☐ Yes ☐ No

If Yes, effective date _____

*Street Address	*Suite #

*City	*State	*Zip Code

Telephone number must be a phone number patients can call to make an appointment.

*Primary Telephone Number	Extension	Fax Number

Additional address - Contact Information

Credentialing Contact information

Please provide the name and contact information of a person who can answer questions about information in this application.

*First name	*Last name

*Telephone Number	Extension	Fax number

*Email Address

Additional address - Accessibility

***Handicap accessibility:** ☐ Yes ☐ No ***Accessible by bus:** ☐ Yes ☐ No

Additional address - Office Hours

Office Hours	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Open Time							
Close Time							

Do you provide 24/7 coverage at this location? ☐ Yes ☐ No

If additional locations need to be added copy this page

CREDENTIALING AND RECREDENTIALING FACILITY AND ALLIED PROVIDER

Type 2 National provider identifier	Tax Identification number

Section 7: Facility Ownership

*denotes a required field

*Ownership Questions
Is facility 100% hospital owned? ☐ Yes ☐ No
If Yes, please provide hospital name: _____
Hospital address: _____
Does the facility and hospital share the same tax ID? ☐ Yes ☐ No
Is your facility recognized by CMS as provider-based? ☐ Yes ☐ No

Section 8: Disclosure Questions

General		
Has the facility or an office, director, or owner ever had any convictions, guilty pleas, civil judgments or actions related to the provision or payment of health care?	☐ Yes	☐ No
Has the facility or its owner ever been subject to a corporate integrity agreement or found to have been non-compliant with self-dealing or anti-kickback laws?	☐ Yes	☐ No
Has the facility or its owner ever been excluded from State or Federal/CMS programs?	☐ Yes	☐ No
Has the facility or any of its owners filed for relief under the US Bankruptcy Code or taken any action to dissolve, terminate, consolidate, merge, or sell all of its assets?	☐ Yes	☐ No
Has the facility's Medicare number/certification ever been revoked, suspended, or terminated?	☐ Yes	☐ No

Section 9: Application Attachments / Checklist

Application Attachment / Checklist
☐ Copy of Accreditation Certificate and/or Accreditation Approval Letter If not accredited, most recent copy of CMS recertification survey or a copy of the CMS letter showing compliance for applicable facilities
☐ Copy of Certificate of Need (CON) required for PET Scanners, MRI, and Megavoltage Radiation Therapy
☐ Copy of Clinical Laboratory Improvement Amendment Certificate (CLIA) Copy of CMS Medicare Certification Letter for applicable facilities
☐ Copy of DEA license (for Substance Abuse facility licensed for Methadone)
☐ Copy of Facility License (Michigan)
☐ Copy of Government entity letter if state owned
☐ Copy of Initial CMS Certification Letter or Health Resources Service Administration (HRSA) letter showing the grant coverage period for Federally Qualified Health Center and Rural Health Clinics

Type 2 National provider identifier	Tax Identification number

Section 9: Application Attachments / Checklist *(continued)*

Application Attachment / Checklist	
☐	Copy of Pharmacy License (Michigan)
☐	Copy of current Professional and General Liability Insurance
☐	Copy of Registration and certificate/inspection information for mammography x-ray machines & and other ionizing equipment

Section 10: Application Signature

I certify that:

- All required certificates and licensures are current and valid.
- The information in this application is complete and accurate.
- I understand that BCBSM/BCN may do an on-site survey after review of this application to verify program compliance and to verify 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 facility will comply with any requests for information, documentation, or on-site review reviews necessary to credential the site.
- I understand the effective date of participation is the date the application is actually approved by BCBSM/BCN 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 BCBSM/BCN, both parties sign the agreement(s), and the processing systems are updated.
- Employed and contracted health care professionals are covered under the facility's general liability insurance or maintain professional liability insurance of $100,000/$300,000 limits.

*Print or Type Name: _____

*Authorizing Signature: _____

*Title: _____

*Date: _____