Instructions for fax cover sheet

We cannot accept handwritten forms. To ensure forms are processed timely, please adhere to the following instructions:

1. Do not hand write anywhere on the forms, otherwise processing will be delayed.

    - From (Insert name of contact person)
    - Date (MM/DD/YY)
    - Type 1 National Provider Identifier
    - State license number
    - When adding an individual to an existing group be sure to include your group's Type 2 National Provider Identifier and a group change form

    o For allied providers
    - From (Insert name of contact person)
    - Date (MM/DD/YY)
    - Type 2 NPI National Provider Identifier
    - Tax identification number

    o For group practices
    - From (Insert name of contact person)
    - Date (MM/DD/YY)
    - Type 2 National Provider Identifier
    - Tax identification number

Instructions for Cl·ŏλfλűλŜă ăŜŏűλ2ƴ ₹₦2Y 2₦λΞλyl·f Ř2ŏdzYŜyű form ădzōYˆλăăλ2ƴ

1. Fax cover sheet must be the first page of your form submission.

2. Fax the registration form and attachments (i.e., signature documents) to 1-866-900-0250. Be sure to fax the registration information separately for each provider. (For example: If you register two or more providers, you must send a fax for each provider. They cannot be bundled into one fax transmission.)

3. You can also mail the completed forms and documentation to:

Provider Enrollment
Blue Cross Blue Shield of Michigan
P.O. Box 217, Southfield, MI 48034

Questions? Call 1-800-822-2761

Blue Cross Blue Shield Blue Care Network of Michigan

FAX OR MAIL 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:

Mail to: Provider Enrollment
Blue Cross Blue Shield of Michigan
P.O. Box 217
Southfield, MI 48034

Form Number: 10593

Type 2 NPI:

Tax Identification Number:

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FACILITY PROVIDER CHANGE FORM

	Type 2 National provider identifier	Tax Identification Number

Section 1: Demographic Data

*denotes a required field

If you are changing the one of more of the following demographic data elements please complete the following sections:

Change EIN/Tax ID number and/or Tax name – Section 1
Request additional network - Section 2
Request to terminate networks - Section 3
Change primary, payment/remit, mailing address - Section 4
Adding or terminating Additional address - Section 5
Changing Facility Ownership - Section 6
Adding and terminating services - Section 7
Attachment checklist - Section 8 (all required documentation must be attached)
Application Signature - Section 9 (all change request requires signature)

*denotes a required information

*Provider Name

*What type of Facility are you? (select 1 per application)

- ☐ Ambulatory Surgery Facility
- ☐ End-Stage Renal Disease
- ☐ Federally Qualified Health Center
- ☐ Free Standing Radiology Center
- ☐ Halfway House
- ☐ Home Health Care
- ☐ Home Infusion Therapy
- ☐ Hospice
- ☐ Long-Term Acute Care Hospital
- ☐ Outpatient Physical Therapy
- ☐ Outpatient Psychiatric Care Facility
- ☐ Rural Health Clinic
- ☐ Skilled Nursing Facility
- ☐ Substance Abuse Facility

County where your primary address is located	BCBSM Facility Code

For Home Health Care, Home Infusion Thrapy or Hospice - Identify the facility services

New Tax Name - If Changing?	New Tax ID # - If Changing?

Tax ID - Effective Date	Tax Exempt: ☐ Yes ☐ No

Substance Abuse Specialty and Services Data

Facility type Substance Abuse must indicate if they are changing or adding specialties and services provided, by checking the appropriate box(es) below.

Servicing Changes:

Substance Abuse Facility

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

☐ Outpatient ☐ Residential (Is Registered Nurse personnel on-site on a 24 hr basis? ☐ Yes ☐ No

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

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FACILITY PROVIDER CHANGE FORM

	Type 2 National provider identifier	Tax Identification Number

Section 2: Requested Networks

If applying to participate with Traditional, Trust PPO, Medicare Advantage PPO, please return a Signature Document for each eligible network. If applying to participate in BCN Commercial, BCN Advantage HMO SM , or Blue Cross Complete, contracts will be sent under separate cover.

You will be notified of your status and the effective dates of affiliation in BCBSM and BCN's networks after credentialing is completed. The signatures on the letter serve as BCBSM's counter signature on the signature document thereby creating a final contract between you and BCBSM. For BCN, you will receive the countersigned affiliation agreements.

BCBSM and BCN do not permit retroactive effective dates.

Select networks you are applying to:

Facility Type	Eligible Networks for Facility Type
Ambulatory Surgery Home Health Care	☐ Traditional ☐ Medicare Advantage PPO ☐ BCN Commercial ☐ BCN Advantage HMO SM ☐ Blue Cross Complete
End-Stage Renal Disease Outpatient Physical Therapy	☐ Traditional ☐ Medicare Advantage PPO ☐ BCN Commercial ☐ Trust PPO ☐ BCN Advantage HMO SM ☐ Blue Cross Complete ☐ Medicare Supplemental
Federally Qualified Health Center	☐ Medicare Advantage PPO ☐ BCN Commercial ☐ BCN Advantage HMO SM ☐ Blue Cross Complete
Halfway House	☐ State of Michigan Mental Health and Substance Abuse
Home Infusion Therapy	☐ Traditional ☐ BCN Commercial ☐ Blue Cross Complete ☐ BCN Advantage HMO SM
Hospice	☐ Traditional ☐ BCN Commercial ☐ Blue Cross Complete
Long-Term Acute Care Hospital Skilled Nursing	☐ Traditional ☐ Medicare Advantage PPO ☐ Medicare Supplemental ☐ BCN Advantage HMO SM ☐ BCN Commercial ☐ Blue Cross Complete
Outpatient Psychiatric Care Substance Abuse	☐ Traditional ☐ State of Michigan Mental Health and Substance Abuse ☐ BCN Commercial ☐ BCN Advantage HMO SM ☐ Blue Cross Complete
Rural Health Clinic	☐ BCN Commercial ☐ BCN Advantage HMO SM ☐ Blue Cross Complete ☐ Medicare Supplemental ☐ Medicare Advantage PPO

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FACILITY PROVIDER CHANGE FORM

	Type 2 National provider identifier	Tax Identification Number

Section 3: Terminating Networks

Select networks to terminate:

Facility Type	Eligible Networks for Facility Type
Ambulatory Surgery Home Health Care	☐ Traditional ☐ Medicare Advantage PPO ☐ BCN Commercial ☐ BCN Advantage HMO SM ☐ Blue Cross Complete
End-Stage Renal Disease Outpatient Physical Therapy	☐ Traditional ☐ Medicare Advantage PPO ☐ BCN Commercial ☐ Trust PPO ☐ BCN Advantage HMO SM ☐ Blue Cross Complete ☐ Medicare Supplemental
Federally Qualified Health Center	☐ Medicare Advantage PPO ☐ BCN Commercial ☐ BCN Advantage HMO SM ☐ Blue Cross Complete
Halfway House	☐ State of Michigan Mental Health and Substance Abuse
Home Infusion Therapy	☐ Traditional ☐ BCN Commercial ☐ Blue Cross Complete ☐ BCN Advantage HMO SM
Hospice	☐ Traditional ☐ BCN Commercial ☐ Blue Cross Complete
Long-Term Acute Care Hospital Skilled Nursing	☐ Traditional ☐ Medicare Advantage PPO ☐ Medicare Supplemental ☐ BCN Advantage HMO SM ☐ BCN Commercial ☐ Blue Cross Complete
Outpatient Psychiatric Care Substance Abuse	☐ Traditional ☐ State of Michigan Mental Health and Substance Abuse ☐ BCN Commercial ☐ BCN Advantage HMO SM ☐ Blue Cross Complete
Rural Health Clinic	☐ BCN Commercial ☐ BCN Advantage HMO SM ☐ Blue Cross Complete ☐ Medicare Supplemental ☐ Medicare Advantage PPO

	Type 2 National provider identifier	Tax Identification Number

Section 4: Address Data - Primary - Remit - Mailing

Changing your Primary address?

*denotes a required field

New Primary address (must be an address where health care services are rendered and may be published in BCBSM/BCN provider directories)		
*Street Address		
*City	*State	*Zip Code
Primary Telephone Number must be a phone number patients can call to make an appointment.		
*Primary Telephone Number	Fax Number	

Primary address - Accessiblity	
*Handicap accessibility: ☐ Yes ☐ No *Accessible by train: ☐ Yes ☐ No *Accessible by bus: ☐ Yes ☐ No	
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	Preferred method of contact? ☐ Email ☐ US Mail **Click here for explanation**

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

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FACILITY PROVIDER CHANGE FORM

	Type 2 National provider identifier	Tax Identification Number

Changing your Remit and/or Mailing address?

Payment/Remit address (if different from your primary address)		
Street Address		
City	State	Zip Code
Payment/Remit telephone number (if different from your Primary telephone number)		

Mailing address (if different from your primary address)		
Street Address		
City	State	Zip Code
Mailing contact name	Mailing contact phone number	

	Type 2 National provider identifier	Tax Identification Number

Section 5: Additional Addresses Data continued

Adding or Terminating an additional address?

☐ **I am terminating this address**

☐ **I am adding this address**

*denotes a required field

Additional Location 1 address (must be an address where health care services are rendered and may be published in BCBSM/BCN provider directories) **If termainating ONLY complete this section**		
*Street Address		
*City	*State	*Zip Code
Primary Telephone Number must be a phone number patients can call to make an appointment.		
*Primary Telephone Number	Fax Number	

Additional Location 1 address - Accessiblity	
*Handicap accessibility: ☐ Yes ☐ No *Accessible by train: ☐ Yes ☐ No *Accessible by bus: ☐ Yes ☐ No	
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	Preferred method of contact? ☐ Email ☐ US Mail

Additional Location 1 – Office Hours							
Office Hours	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Open Time							
Close Time							

	Type 2 National provider identifier	Tax Identification Number

Section 5: Additional Addresses Data continued

☐ **I am terminating this address**

☐ **I am adding this address**

*denotes a required field

Additional Location 2 address (must be an address where health care services are rendered and may be published in BCBSM/BCN provider directories)		
*Street Address		
*City	*State	*Zip Code
Primary Telephone Number must be a phone number patients can call to make an appointment.		
*Primary Telephone Number	Fax Number	

Additional Location 2 address - Accessiblity							
*Handicap accessibility: ☐ Yes ☐ No *Accessible by train: ☐ Yes ☐ No *Accessible by bus: ☐ Yes ☐ No							
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				Preferred method of contact? ☐ Email ☐ US Mail			
Additional Location 2 – Office Hours							
Office Hours	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Open Time							
Close Time							

	Type 2 National provider identifier	Tax Identification Number

Section 5: Additional Addresses Data continued

☐ **I am terminating this address**

☐ **I am adding this address**

*denotes a required field

Additional Location 3 address (must be an address where health care services are rendered and may be published in BCBSM/BCN provider directories)		
*Street Address		
*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	

Additional Location 3 address - Accessiblity	
*Handicap accessibility: ☐ Yes ☐ No *Accessible by train: ☐ Yes ☐ No *Accessible by bus: ☐ Yes ☐ No	
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	Fax Number
Email	Preferred method of contact? ☐ Email ☐ US Mail

Additional Location 3 – Office Hours

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

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FACILITY PROVIDER CHANGE FORM

	Type 2 National provider identifier	Tax Identification Number

Section 6: Facility Ownership

Are you changing Facility Ownership?

Facility Ownership - List name/organization, address, occupation and percentage of ownership. Attach additional pages if needed.

Name	Address	Occupation	Percent

Additional 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 the facility included in the hospital organization chart? ☐ Yes ☐ No

Are the facility's charges and costs included in the hospital's cost report? ☐ Yes ☐ No

Are the facility's utilization evaluation and/or quality assurance plans included in the hospital's utilization review program? ☐ Yes ☐ No

If yes to above questions, please provide the BCBSM hospital facility code: _____

Is your facility recognized by CMS as provider-based? ☐ Yes ☐ No

Staffing

Medical Director name	License number
Medical Director credentials (MD, DO, Specialty)	Medical Director Type 1 NPI
Nursing Director name	License number

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

If Outside Agency is used, please provide the agency's name: _____

Does the facility have a governing or advisory board? ☐ Yes ☐ No

Does the facility's governing or advisory board include community representation? ☐ Yes ☐ No

Please provide a complete staff roster for your facility including names, credentials, job titles, and **license numbers** for all professional/clinical staff members

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FACILITY PROVIDER CHANGE FORM

	Type 2 National provider identifier	Tax Identification Number

General

Has the facility or an officer, 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 7: Have you added or Terminated any Service(s)?

☐ Ambulatory Surgery Facility

Does the facility have a written agreement with an area hospital for the prompt transfer of patients? ☐ Yes ☐ No

Please identify the name of the hospital: _____

Is a Michigan licensed physician always on site when patients are on the facility premises? ☐ Yes ☐ No

Please list name and NPI of the Anesthesthesiology Groups who practices at your facility:

	Name	NPI
1.		
2.		
3.		

☐ End Stage Renal Disease

List the number of dialysis stations at your facility: _____

Does your ESRD facility provide:

Home Hemodialysis sevices? ☐ Yes ☐ No

In-Facility Hemodialysis services? ☐ Yes ☐ No

Peritoneal Dialysis? ☐ Yes ☐ No

☐ Halfway House

Please identify the following: # of male beds _____ # of female beds _____

Check the psychotherapy and counseling services provided at your facility:

☐ Didactics ☐ Group ☐ Individual ☐ Self-help group therapy

☐ Treatment not provided ☐ Other (describe) _____

Servicing Questions by Facility Type continued on next page

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FACILITY PROVIDER CHANGE FORM

	Type 2 National provider identifier	Tax Identification Number

☐ **Home Health Care**
Please indicate specific services provided:
☐ Adults ☐ Pediatrics ☐ Telemonitoring

☐ **Home Infusion Therapy**
Please indicate specific services provided:
☐ Adults ☐ Pediatrics ☐ Implanted pain or Baclofen pump management

☐ **Hospice**
Check the box next to the levels of care provided by the facility either directly or on a contracted basis:
☐ Routine Home Care ☐ Continuous Home Care ☐ Inpatient Respite Care
☐ General Inpatient Care ☐ Nursing Home care with Hospice support (5th level)
Where care is provided on a contracted basis, provide the name of the contracted facility:
_____

☐ **Long-Term Acute Care Hospital**
Does the facility have a written agreement with an area hospital for the prompt transfer of patients? ☐ Yes ☐ No
Please identify the name of the hospital: _____

☐ **Outpatient Physical Therapy** (Check which services are provided at your facility):
☐ Physical ☐ Occupational ☐ Speech
Indicate the date the facility began providing services to patients
(must be operational for 6 months prior to application being submitted to BCBSM): _____
Treats patients with autism spectrum disorder? ☐ Yes ☐ No

☐ **Skilled Nursing Facility** (indicate specific services provided onsite):
☐ Bariatric Patients ☐ Blood Transfusions ☐ Tracheostomy
☐ IV Therapy ☐ Peritoneal Dialysis ☐ High Level Oxygen
☐ Wound Care ☐ Hemodialysis ☐ Vent

Urgent Care Center
Is the UCC open for Business? Yes - Date opened:_____ No - Date will open for business:_____
Check box to identify the type of services provided:
☐ Casting ☐ CLIA Waived Rapid tests ☐ Laceration repair ☐ Splinting ☐ Stiching
☐ On-site Cash Cart ☐ On-site Cash Lab ☐ On-site defibrillator ☐ On-site Xray
If On-site Xray was checked, does a Board Certified Radiologist read the x-rays? ☐ Yes ☐ No
List name of Radiologist or Radiology Group who reads the x-rays: _____
Is there a physician on-site at all times? ☐ Yes ☐ No
Is there an ACLS certified practitioner on-site at all times? ☐ Yes ☐ No

Servicing Questions by Facility Type continued on next page

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FACILITY PROVIDER CHANGE FORM

	Type 2 National provider identifier	Tax Identification Number

Urgent Care Center continued

Identify total number of staff whork at this site as well as number of staff pr shift:

Staff Type	Total	Per Shift
MD/DO		
PA		
RN		
ER RN		
Medical Assistant		
Other (specify)		

Does this site also have a physician practice that accepts referrals or provides primary care services? ☐ Yes ☐ No

Behavioral Health Servicing Questions

☐ **Outpatient Psychiatric Care**

Do you have a Board Certified child or adolescent psychiatrist on staff? ☐ Yes ☐ No

Do you have a Board Certified Analysts (BCBAs) who perform applied behavior analysis treatment for autism spectrum disorders? ☐ Yes ☐ No

Check all **Psychiatric Levels of Care** that apply:

Mental Health Outpatient Services	☐ Child	☐ Adolescent	☐ Adult	☐ Geriatric
Intensive Outpatient Mental Health 3-4 hrs/day	☐ Child	☐ Adolescent	☐ Adult	☐ Geriatric
Partial Hospitalization Mental Health	☐ Child	☐ Adolescent	☐ Adult	☐ Geriatric
Inpatient Mental Health	☐ Child	☐ Adolescent	☐ Adult	☐ Geriatric

Check all **Psychiatric Specialty Services** that apply:

- ☐ 23-hour Observation
- ☐ Inpatient Electroconvulsive Therapy
- ☐ Outpatient Electroconvulsive Therapy
- ☐ Halfway House
- ☐ Group Home
- ☐ In Home Mental Health Psychiatric RN
- ☐ In Home Mental Health Social Work
- ☐ Urgent/Same Day Evaluations
- ☐ Crisis/Evaluation in ER
- ☐ Care Management Services

☐ **Substance Abuse Facility**

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

☐ Outpatient ☐ Residential (Is Registered Nurse personnel on-site on a 24 hr basis? ☐ Yes ☐ No

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

Check all Substance Abuse Levels of Care that apply and applicable age group:

Substance Abuse Outpatient Services	☐ Adolescent	☐ Adult	☐ Geriatric
Intensive Outpatient Substance Abuse 3-4 hrs/day	☐ Adolescent	☐ Adult	☐ Geriatric
Partial Substance Abuse Hospitalization	☐ Adolescent	☐ Adult	☐ Geriatric
Residential/Inpatient Substance Abuse	☐ Adolescent	☐ Adult	☐ Geriatric
Residential/Inpatient Substance Abuse Sub Acute Detox	☐ Adolescent	☐ Adult	☐ Geriatric
Drug Ambulatory Outpatient Detox	☐ Adolescent	☐ Adult	☐ Geriatric
Alcohol Ambulatory Outpatient Detox	☐ Adolescent	☐ Adult	☐ Geriatric

	Type 2 National provider identifier	Tax Identification Number

Section 8: Application Attachments/Checklist

Application Attachments/Checklist

___ Copy of Facility License

___ Copy of current Professional and General Liability Insurance

___ 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 substantial compliance for applicable facilities

___ Copy of Professional Membership for applicable facilities

___ Copy of CMS Medicare Certification Letter for applicable facilities

___ Federal Tax Deposit Coupon (Form 8109), copy of facility's IRS notification letter (Form SS4-147c) or EFTPS (Form 9787)

___ IRS document authorizing tax exempt status (if applicable)

___ Evidence/list of the Facility's governing/advisory board including community representation

___ Copy of the facility's current staff roster including names, credential, job titles, and license numbers for all professional/clinical staff

___ Certificate of Need (CON) required for PET Scanners, MRI, and Megavoltage Radiation Therapy

___ Registration and certificate/inspection information for mammography, x-ray machines & all other ionizing equipment

___ Copy of DEA license (for Substance Abuse facility licensed for Methadone)

___ Copy of BCBSM EON approval (for ASFs only)

___ A photograph of the exterior of your facility to bcnproviderpictures@bcbsm.com for our website if you have not submitted one. The photos should be digital and meet these specifications:

- Size: 156 pixels wide x 125 pixels tall
- Resolution between 150 and 300 dots per inch (dpi)
- File type should be .jpg, .bmp or .psd
- There should be no borders around the photo
- File size should be less than 200K

	Type 2 National provider identifier	Tax Identification Number

Section 9: Application Signature

I certify that:

- The information contained in this application is complete and accurate
- 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 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.
- Written criteria for participation on 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.
- Employed and contracted health care professionals are covered under the facility's general liability insurance or maintain professionals liability insurance of $100,000/$300,000 limits.
- 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 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.
- I understand BCBSM's payment rates and the terms of its standard participation agreement are not negotiable.
- BCN shall be held harmless for any claims, lawsuits, etc. that arise as a result of the misrepresentation of information provided in response to this application.

Ambulatory Surgery Facility Specific Attestations (if applicable facility type)

- All BCBSM Evidence of Need requirements for this facility have been met as demonstrated by the EON Notification
- A Michigan licensed physician is always on site when patients are on the premises.

Application Signature continued on next page

	Type 2 National provider identifier	Tax Identification Number

Section 9: Application Signature continued

Home Infusion Therapy Specific Attestations (if applicable facility type)

- This facility directly employs a registered pharmacist and a registered nurse.
- This HIT facility has a system that ensures prompt delivery and storage of pharmaceuticals and medical supplies with ability to deliver services to the member's home within 24 hours of receipt of a physician's order.
- This facility has an acceptable medical waste disposal system for in-home use, and a facility recall policy in the event of a FDA recall.
- A physician signed care plan is updated at least every 30 days.
- Any RN providing patient care has specialized home infusion training.

Hospice Specific Attestations (if applicable facility type)

- The facility has volunteer staff sufficient to provide administration or direct patient care equaling at least five percent of total patient hours of patient care provided by all paid employees and contract staff.
- The facility maintains a ratio of at least 80 percent home care days and no more than 20 percent inpatient days for BCBSM members.

Outpatient Physical Therapy Specific Attestations (if applicable facility type)

- A Michigan licensed physical therapist is on site when physical therapy is provided; a certified Occupational Therapist is on site when occupational therapy is provided; and a certified Speech Language Pathologist is on site when speech-language therapy is provided.

I certify that I will notify Blue Cross and Blue Shield of Michigan and Blue Care Network immediately in witing of changes affecting this data.

*Print or Type Name	*Authorizing Signature	*Title	*Date

When Completed