

Non-clinical health worker 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@mibluccrosscomplete.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.

| | | |
|--|--|-----------|
| Fax to: | 1-855-306-9762 Attn: Provider Network Operations | |
| Email to: | BCCproviderdata@mibluccrosscomplete.com | |
| From: | | |
| Date: | | |
| Type 1 NPI: | | |
| Type 2 NPI: (if applicable) | | |
| Tax identification number: | | |
| Is the provider enrolled in CHAMPS**? | Yes | No |
| | If yes, Effective date: | End date: |
| If "No", 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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| | | |
|---------------------------|------------|------------|
| Tax Identification Number | Type 1 NPI | Type 2 NPI |
|---------------------------|------------|------------|

Section 1: Demographic data

*denotes a required field

| | | | |
|---|-----|------------------|--|
| 1. *Provider name and title/degree | | | |
| 2. *Provider type description | | | |
| 3. Gender | | 4. Date of Birth | |
| 5. Name of organization (if applicable) | | | |
| 6. *Tax identification number | | | |
| 7. *Tax identification name (as filed with the IRS) | | | |
| 8. *Tax exempt? | Yes | No | |
| 9. Associated NPI numbers | | | |
| 10. *Medicaid number | | | |
| 11. *Medicare number | | | |

Section 2: Address information

*denotes a 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. Fax number | |
| h. Email | |
| i. Areas Served (County/Counties Served) | |
| 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 - Non clinical health workers must maintain: vehicle liability coverage (as applicable or as required by Michigan law) and professional or general liability coverage in amounts commensurate with applicable industry standards (minimum limits of \$100,000 per incident / \$300,000 annual aggregate).

Please provide copies of all fact sheets.

| | | |
|--------------------------------------|------------|---------------|
| a. Professional or general liability | Occurrence | Per aggregate |
| b. Expiration date | | |
| c. Liability coverage is renewed | Annually | Continuous |
| d. Carrier name | | |

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Section 5 – Enrollment signature

* denotes a 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 this 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 actually 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 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 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 | * Practitioner Signature and title | *Date |
|---------------------|------------------------------------|-------|

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[Non-clinical health worker enrollment required document checklist](#)

| Provider classification | To avoid processing delays, please ensure all items are submitted |
|--|--|
| Non-clinical health worker Doula | <ul style="list-style-type: none"> • Professional or General Liability insurance • Michigan Department of Health and Human Services Doula registry approval email • Type 1 National Provider Identifier • Type 2 National Provider Identifier (if applicable) • W9 form |
| Non-clinical health worker Community health worker/representative | <ul style="list-style-type: none"> • Professional or General Liability insurance • Type 1 National Provider Identifier • Type 2 National Provider Identifier (if applicable) • W9 form |
| Non-clinical health worker Lifestyle Coach | <ul style="list-style-type: none"> • Professional or General Liability insurance • Type 1 National Provider Identifier • Type 2 National Provider Identifier (if applicable) • W9 form |