Instructions for Completion of the Provider Survey via BD LinkSM Web Portal

Please complete all Provider Survey information pertaining to your facility’s current and active transplant services for adults (18 years and older) and/or pediatrics (17 years old and younger). Please be sure that your application is complete before submitting.

Additional program materials for the Blue Distinction Centers for Transplants program are available at: www.bcbs.com

This is the Quality based Selection Criteria dimension of the evaluation process for the Blue Distinction Centers for Transplants designation. There are 12 main sections; complete Sections 1, 2, and 12 (Provider Information, Facility Information, and Additional Information & Attestation), and all other transplant section(s) that are applicable to your facility.

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<td>10. Adult Autologous/Allogeneic Bone Marrow/Stem Cell Transplant</td>
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<td>12. Additional Information &amp; Attestation</td>
<td>Not Applicable</td>
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</table>
PROVIDER INFORMATION

FACILITY NAME:
ADDRESS 1:
ADDRESS 2:
CITY:
STATE:
ZIP:

FACILITY’S NATIONAL PROVIDER IDENTIFIER (NPI):
FACILITY’S TAX ID:
FACILITY’S CMS CERTIFICATION NUMBER (MEDICARE ID NUMBER):

If the National Provider Identifier (NPI) listed above is incorrect or blank, please provide the correct number:

Does your facility share a National Provider Identifier (NPI) with another facility (or facilities)?
☐ YES  ☐ NO
   If YES, please provide each facility’s name(s) and address(es).

If your facility does not have a National Provider Identifier (NPI), please provide an explanation:

If the Tax ID listed above is incorrect or blank, please provide the correct number:

Does your facility share a Tax ID with another facility (or facilities)?
☐ YES  ☐ NO
   If YES, please provide each facility’s name(s) and address(es).

If your facility does not have a Tax ID, please provide an explanation:

If the CMS Certification Number listed above is incorrect or blank, please provide the correct number:

Does your facility share a CMS Certification Number with another facility (or facilities)?
☐ YES  ☐ NO
   IF YES, please provide each such facility’s name(s) and address(es).

If your facility does not have a CMS Certification Number, please provide an explanation:

If any of the Provider information included above is incorrect, please contact your local Blue Cross and/or Blue Shield Plan contact to have the information corrected promptly.

FACILITY INFORMATION

1. Please provide the following information for the person responsible for completing and submitting this Provider Survey:

   Primary Contact
   Name:
   Title:
   Phone:
   E-mail:
2. Please provide your facility’s legal contact. This individual may be contacted in the event there are questions related to potential brand conflicts that need to be addressed.

Facility Legal Counsel/Representative Contact:
Name:
Title:
Phone:
E-mail:

3. The Blue Distinction Centers for Transplants designations are given only to individual facilities (i.e., unique bricks-and-mortar facilities with unique addresses). Any facility with multiple locations (different addresses) must complete a separate Provider Survey for each location. Health systems and other groups of multiple facilities will not be designated collectively.

3a. Is the quality information submitted in this survey (e.g. accreditations, volume, outcomes) only for the single facility whose name and address are listed in the Provider Information Section, above, and for no other facilities or locations?

☐ YES  ☐ NO

If NO, please explain.

3b. The evaluation of Blue Plans healthcare claims data requires distinct provider identifiers to be present on submitted claims in order to match them back to your facility’s application. Are claims submitted by your facility to your Blue Plan clearly distinguished from other facilities by using a distinct facility name, distinct Tax ID, distinct NPI, and distinct Plan Provider ID? If you do not have insight on this question, simply answer DO NOT KNOW. This is for informational purposes only.

☐ YES  ☐ NO  ☐ DO NOT KNOW

If NO or DO NOT KNOW, please provide guidance on the best method of distinguishing your facility’s claims.

4. Please indicate which of the following statements describes your facility’s current accreditation status: (Check all that apply)

☐ My facility is fully accredited (without provision or condition) by The Joint Commission (TJC) in the Hospital Accredited Program.  www.jointcommission.org

☐ My facility is fully accredited by Healthcare Facilities Accreditation Program (HFAP) of the Accreditation Association for Hospital and Health Systems (AAHHS) as an acute care hospital.  www.hfap.org

☐ My facility is fully accredited by DNV GL Healthcare's National Integrated Accreditation for Healthcare Organizations (NIAHO®) Hospital Accreditation Program.  www.dnvaccreditation.com

☐ My facility is fully accredited by the Center for Improvement in Healthcare Quality (CIHQ) in the Hospital Accreditation Program.  www.cihq.org

☐ My facility is not fully accredited by any of the above organizations.

5. Is your facility a comprehensive acute care facility that offers ALL of the following services on site?
● Intensive care unit;
● Emergency Room or Emergency Services that include plans or systems for onsite emergency admission of acute care patients with 24/7 availability of onsite medical response teams;
● 24/7 availability of in-house emergency physician coverage;
● Diagnostic radiology including MRI and CT;
● 24/7 availability of inpatient pharmacy services (may include alternative nighttime access when pharmacy is closed);
● Blood bank or 24/7 access to blood bank services; AND
● 24/7 availability of Clinical Laboratory Improvement Amendments (CLIA) accredited laboratory services.

☐ YES  ☐ NO

If NO, please explain.

6. Please identify all transplant program(s) for which you intend to submit a Provider Survey. Questions specific to individual transplant program(s) will be displayed based on the response provided below.

My Facility intends to submit a Provider Survey for the following transplant programs (Check all that applies):

☐ Adult Heart Transplant
☐ Adult Lung Transplant
☐ Adult Liver Transplant (Deceased)
☐ Adult Liver Transplant (Living)
☐ Adult Pancreas Transplant
☐ Pediatric Heart Transplant
☐ Pediatric Liver Transplant
☐ Adult Autologous/Allogeneic Bone Marrow/Stem Cell Transplant
☐ Pediatric Autologous/Allogeneic Bone Marrow/Stem Cell Transplant

☐ My facility does NOT intend to submit a Provider Survey for any of the above transplant program designations.

Adult Heart Transplant Program Information

*Questions in this section that refer to “my,” “your,” “my facility’s” or “your facility’s program” all refer to your facility’s own adult heart transplant program (not the Blue Distinction Centers for Transplants program).*

**Questions 7 through 15 pertain to your facility’s Adult (18 years and older) Heart Transplant Program.**

7. Is the adult heart transplant program’s primary contact different than the primary contact reported in Question 1?

☐ YES  ☐ NO

7a. Adult Heart Transplant Program’s Primary Contact
Name:
8. Is your adult heart transplant program currently certified by and in good standing with Centers for Medicare & Medicaid Services (CMS)?

☐ YES  ☐ NO

If NO, please explain.

9. Does your adult heart transplant program meet United Network for Organ Sharing (UNOS) guidelines (as outlined in the UNOS policy and by-laws) and is it currently in good standing with UNOS?

☐ YES  ☐ NO

If NO, please explain.

10. Does your adult heart transplant program perform Ventricular Assist Device implants as a bridge to transplant (BTT)?

☐ YES  ☐ NO

11. Does your facility have 24 hour, seven day availability of cardiac surgery services?

☐ YES  ☐ NO

12. Does your facility have a cardiac rehabilitation program and/or the ability to make appropriate referrals to cardiac rehabilitation programs outside your facility?

☐ YES  ☐ NO

13. Does the cardiac rehabilitation program at your facility (or the cardiac rehabilitation to which your heart transplant program refers patients) hold the American Association of Cardiovascular and Pulmonary Rehabilitation (AACVPR) Program Certification?

☐ YES  ☐ NO

**Transplant Surgeon and Physician Information**

14. Please complete the following table for all transplant surgeons who actively perform adult heart transplant procedures at your facility.

The instructions for completing the table include:
- **Column A**: Please enter Surgeon’s first name.
- **Column B**: Please enter Surgeon’s last name.
- **Column C**: Please enter Surgeon’s National Provider Identifier (NPI) number. The NPI information can be obtained online in a searchable database available at: [http://npidb.org/npi/](http://npidb.org/npi/)
- **Column D**: Selecting ‘Yes’ in this column indicates the Surgeon is board certified (or in the process of becoming board certified) by the American Board of Surgery or equivalent such as the American Osteopathic Board of Surgery and/or Royal College of Physicians and Surgeons of Canada.
- **Column E**: Please select ‘Yes’ or ‘No’ indicating if the Surgeon listed in that row is your facility’s UNOS Primary Surgeon.

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<td>Surgeon’s <strong>First</strong> Name</td>
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<td>Surgeon’s Type 1 National Provider Identifier</td>
<td>Board Certified by American Board of Surgery, or Equivalent</td>
<td>Facility’s UNOS Primary Surgeon?</td>
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- **Column E**: Please select ‘Yes’ or ‘No’ indicating if the Physician listed in that row is your facility’s UNOS Primary Physician.

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<td>Physician’s Type 1 National Provider Identifier</td>
<td>Board Certified by American Board of Internal Medicine, or Equivalent</td>
<td>Facility’s UNOS Primary Physician?</td>
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15. Please complete the following table for all **transplant physicians** who actively manage adult heart transplant patients at your facility.

The instructions for completing the table include:
- **Column A**: Please enter Physician’s first name
- **Column B**: Please enter Physician’s last name
- **Column C**: Please enter Physician’s National Provider Identifier (NPI) number. The NPI information can be obtained online in a searchable database available at: [http://npidb.org/npi/](http://npidb.org/npi/)
- **Column D**: Selecting ‘Yes’ in this column indicates the Physician is board certified in Internal Medicine (or in the process of becoming board certified) by the American Board of Internal Medicine, the American Osteopathic Board of Internal Medicine, or the Royal College of Physicians and Surgeons of Canada.
- **Column E**: Please select ‘Yes’ or ‘No’ indicating if the Physician listed in that row is your facility’s UNOS Primary Physician.
Adult Lung Transplant Program Information

Questions in this section that refer to “my,” “your,” “my facility’s” or “your facility’s program” all refer to your facility’s own adult lung transplant program (not the Blue Distinction Centers for Transplants program).

Questions 16 through 21 pertain to your facility’s Adult (18 years and older) Lung Transplant Program.

16. Is the adult lung transplant program’s primary contact different than the primary contact reported in Question 1?

☐ YES □ NO

16a. Adult Lung Transplant Program’s Primary Contact
Name:
Title:
Phone:
E-mail:

17. Is your adult lung transplant program currently certified by and in good standing with Centers for Medicare & Medicaid Services (CMS)?

☐ YES □ NO

If NO, please explain.

18. Does your adult lung transplant program meet United Network for Organ Sharing (UNOS) guidelines (as outlined in the UNOS policy and by-laws) and is it currently in good standing with UNOS?

☐ YES □ NO

If NO, please explain.

19. Does your facility have 24 hour, seven day availability of Bronchoscopy/Endoscopy services?

☐ YES □ NO

Transplant Surgeon and Physician Information

20. Please complete the following table for all transplant surgeons who actively perform adult lung transplant procedures at your facility.

The instructions for completing the table include:

- **Column A**: Please enter Surgeon’s first name.
- **Column B**: Please enter Surgeon’s last name.
- **Column C**: Please enter Surgeon’s National Provider Identifier (NPI) number. The NPI information can be obtained online in a searchable database available at: [http://npidb.org/npi/](http://npidb.org/npi/)
- **Column D**: Selecting ‘Yes’ in this column indicates the Surgeon is board certified (or in the process of becoming board certified) by the American Board of Surgery or equivalent such as...
the American Osteopathic Board of Surgery and/or Royal College of Physicians and Surgeons of Canada.

- **Column E**: Please select ‘Yes’ or ‘No’ indicating if the Surgeon listed in that row is your facility’s UNOS Primary Surgeon.

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21. Please complete the following table for all transplant physicians who actively manage adult lung transplant patients at your facility.

The instructions for completing the table include:
- **Column A**: Please enter Physician’s first name.
- **Column B**: Please enter Physician’s last name.
- **Column C**: Please enter Physician’s National Provider Identifier (NPI) number. The NPI information can be obtained online in a searchable database available at: [http://npidb.org/npi/](http://npidb.org/npi/)
- **Column D**: Selecting ‘Yes’ in this column indicates the Physician is board certified in Internal Medicine (or in the process of becoming board certified) by the American Board of Internal Medicine, the American Osteopathic Board of Internal Medicine, or the Royal College of Physicians and Surgeons of Canada.
- **Column E**: Please select ‘Yes’ or ‘No’ indicating if the Physician listed in that row is your facility’s UNOS Primary Physician.

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ADULT LIVER (DECEASED) TRANSPLANT PROGRAM INFORMATION

Questions in this section that refer to “my,” “your,” “my facility’s” or “your facility’s program” all refer to your facility’s own adult deceased donor liver transplant program (not the Blue Distinction Centers for Transplants program).
Questions 22 through 26 pertain to your facility’s Adult (18 years and older) Deceased Donor Liver Transplant Program.

22. Is the adult deceased donor liver transplant program’s primary contact different than the primary contact reported in Question 1?

☐ YES  ☐ NO

22a. Adult Deceased Donor Liver Transplant Program’s Primary Contact
Name: 
Title: 
Phone: 
E-mail: 

23. Is your adult deceased donor liver transplant program currently certified by and in good standing with Centers for Medicare & Medicaid Services (CMS)?

☐ YES  ☐ NO

If NO, please explain.

24. Does your adult deceased donor liver transplant program meet United Network for Organ Sharing (UNOS) guidelines (as outlined in the UNOS policy and by-laws) and is it currently in good standing with UNOS?

☐ YES  ☐ NO

If NO, please explain.

Transplant Surgeon and Physician Information

25. Please complete the following table for all transplant surgeons who actively perform adult liver transplant procedures at your facility.

The instructions for completing the table include:

- **Column A**: Please enter Surgeon’s first name.
- **Column B**: Please enter Surgeon’s last name.
- **Column C**: Please enter Surgeon’s National Provider Identifier (NPI) number. The NPI information can be obtained online in a searchable database available at: [http://npidb.org/npi/](http://npidb.org/npi/)
- **Column D**: Selecting ‘Yes’ in this column indicates the Surgeon is board certified (or in the process of becoming board certified) by the American Board of Surgery or equivalent such as the American Osteopathic Board of Surgery and/or Royal College of Physicians and Surgeons of Canada.
- **Column E**: Please select ‘Yes’ or ‘No’ indicating if the Surgeon listed in that row is your facility’s UNOS Primary Surgeon.

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26. Please complete the following table for all **transplant physicians** who actively manage adult liver transplant patients at your facility.

The instructions for completing the table include:
- **Column A**: Please enter Physician’s first name.
- **Column B**: Please enter Physician’s last name.
- **Column C**: Please enter Physician’s National Provider Identifier (NPI) number. The NPI information can be obtained online in a searchable database available at: [http://npidb.org/npi/](http://npidb.org/npi/)
- **Column D**: Selecting ‘Yes’ in this column indicates the Physician is board certified in Internal Medicine (or in the process of becoming board certified) by the American Board of Internal Medicine, the American Osteopathic Board of Internal Medicine, or the Royal College of Physicians and Surgeons of Canada.
- **Column E**: Please select ‘Yes’ or ‘No’ indicating if the Physician listed in that row is your facility’s UNOS Primary Physician.

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**ADULT LIVER (LIVING) TRANSPLANT PROGRAM INFORMATION**

The question in this section that refers to “my,” “your,” “my facility’s” or “your facility’s program” all refer to your facility’s own adult living donor liver transplant program (not the Blue Distinction Centers for Transplants program).

Question 27 pertains to your facility’s Adult (18 years and older) Living Donor Liver Transplant Program.

**NOTE:** Facilities applying for Adult Living Donor Liver Transplant designation must be considered eligible for the Adult Deceased Donor Liver Transplant Program in order to be considered eligible for the Adult Living Donor Liver transplant program.
27. Does your adult living donor liver transplant program meet United Network for Organ Sharing (UNOS) guidelines (as outlined in the UNOS policy and by-laws) and is it currently in good standing with UNOS?

☐ YES  ☐ NO

If NO, please explain.

ADULT PANCREAS TRANSPLANT PROGRAM INFORMATION

Questions in this section that refer to “my,” “your,” “my facility’s” or “your facility’s program” all refer to your facility’s own adult pancreas transplant program (not the Blue Distinction Centers for Transplants program).

Questions 28 through 33 pertain to your facility’s Adult (18 years and older) Pancreas Transplant Program.

28. Is the adult pancreas transplant program’s primary contact different than the primary contact reported in Question 1?

☐ YES  ☐ NO

28a. Adult Pancreas Transplant Program’s Primary Contact
Name:
Title:
Phone:
E-mail:

29. Is your adult pancreas transplant program currently certified by and in good standing with Centers for Medicare & Medicaid Services (CMS)?

☐ YES  ☐ NO

If NO, please explain.

30. Does your adult pancreas transplant program meet United Network for Organ Sharing (UNOS) guidelines (as outlined in the UNOS policy and by-laws) and is it currently in good standing with UNOS?

☐ YES  ☐ NO

If NO, please explain.

31. Does the pre-transplant evaluation for an adult pancreas transplant include a cardiologist evaluation?

☐ YES  ☐ NO

Transplant Surgeon and Physician Information

32. Please complete the following table for all transplant surgeons who actively perform adult pancreas transplant procedures at your facility.

The instructions for completing the table include:
- **Column A**: Please enter Surgeon’s first name.
- **Column B**: Please enter Surgeon’s last name.
- **Column C**: Please enter Surgeon’s National Provider Identifier (NPI) number. The NPI information can be obtained online in a searchable database available at: [http://npidb.org/npi/](http://npidb.org/npi/)
- **Column D**: Selecting ‘Yes’ in this column indicates the Surgeon is board certified (or in the process of becoming board certified) by the American Board of Surgery or equivalent such as the American Osteopathic Board of Surgery and/or Royal College of Physicians and Surgeons of Canada.
- **Column E**: Please select ‘Yes’ or ‘No’ indicating if the Surgeon listed in that row is your facility’s UNOS Primary Surgeon.

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33. Please complete the following table for all transplant physicians who actively manage adult pancreas transplant patients at your facility.

The instructions for completing the table include:
- **Column A**: Please enter Physician’s first name.
- **Column B**: Please enter Physician’s last name.
- **Column C**: Please enter Physician’s National Provider Identifier (NPI) number. The NPI information can be obtained online in a searchable database available at: [http://npidb.org/npi/](http://npidb.org/npi/)
- **Column D**: Selecting ‘Yes’ in this column indicates the Physician is board certified in Internal Medicine (or in the process of becoming board certified) by the American Board of Internal Medicine, the American Osteopathic Board of Internal Medicine, or the Royal College of Physicians and Surgeons of Canada.
- **Column E**: Please select ‘Yes’ or ‘No’ indicating if the Physician listed in that row is your facility’s UNOS Primary Physician.

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PEDIATRIC HEART TRANSPLANT PROGRAM INFORMATION
Questions in this section that refer to “my,” “your,” “my facility’s” or “your facility’s program” all refer to your facility’s own pediatric heart transplant program (not the Blue Distinction Centers for Transplants program).

Questions 34 through 42 pertain to your facility’s Pediatric (17 years and younger) Heart Transplant Program.

34. Is the pediatric heart transplant program’s primary contact different than the primary contact reported in Question 1?

☐ YES ☐ NO

34a. Pediatric Heart Transplant Program’s Primary Contact
Name:
Title:
Phone:
E-mail:

35. Is your pediatric heart transplant program currently certified by and in good standing with Centers for Medicare & Medicaid Services (CMS)?

☐ YES ☐ NO

If NO, please explain.

36. Does your pediatric heart transplant program meet United Network for Organ Sharing (UNOS) guidelines (as outlined in the UNOS policy and by-laws) and is it currently in good standing with UNOS?

☐ YES ☐ NO

If NO, please explain.

37. Does your facility have a Ventricular Assist Device (VAD)/Extra Corporeal Membrane Oxygenation (ECMO) program and/or a process/plan in place to allow patients to have access to these services?

☐ YES ☐ NO

38. Does your facility have 24 hour, seven day availability of cardiac surgery services for pediatric patients?

☐ YES ☐ NO

39. Does your facility have a cardiac rehabilitation program and/or the ability to make appropriate referrals to cardiac rehabilitation programs outside your facility?

☐ YES ☐ NO

40. Has your facility performed pediatric (17 years and younger) congenital heart surgery (open and closed) in the most recent 12 months?

☐ YES ☐ NO
40a. Report your facility’s pediatric congenital heart surgery (open and closed) case volume for the most recent 12 months

40b. Do the cardiothoracic surgeons with cardiac surgical privileges at your facility participate in the Society of Thoracic Surgeons (STS) Congenital Heart Surgery Database and submit data on all congenital heart surgeries?

☐ YES  ☐ NO

Transplant Surgeon and Physician Information

41. Please complete the following table for all transplant surgeons who actively perform pediatric heart transplant procedures at your facility.

The instructions for completing the table include:
- **Column A**: Please enter Surgeon’s first name.
- **Column B**: Please enter Surgeon’s last name.
- **Column C**: Please enter Surgeon’s National Provider Identifier (NPI) number. The NPI information can be obtained online in a searchable database available at: http://npidb.org/npi/
- **Column D**: Selecting ‘Yes’ in this column indicates the Surgeon is board certified (or in the process of becoming board certified) by the American Board of Surgery or equivalent such as the American Osteopathic Board of Surgery and/or Royal College of Physicians and Surgeons of Canada.
- **Column E**: Please select ‘Yes’ or ‘No’ indicating if the Surgeon listed in that row is your facility’s UNOS Primary Surgeon.

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<td>Surgeon’s Type 1 National Provider Identifier</td>
<td>Board Certified by American Board of Surgery, or Equivalent</td>
<td>Facility’s UNOS Primary Surgeon?</td>
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42. Please complete the following table for all transplant physicians who actively manage pediatric heart transplant patients at your facility.

The instructions for completing the table include:
- **Column A**: Please enter Physician’s first name.
- **Column B**: Please enter Physician’s last name.
- **Column C**: Please enter Physician’s National Provider Identifier (NPI) number. The NPI information can be obtained online in a searchable database available at: http://npidb.org/npi/
- **Column D**: Selecting ‘Yes’ in this column indicates the Physician is board certified in Internal Medicine (or in the process of becoming board certified) by the American Board of Internal Medicine.
Columns B, C, D, E: Please select ‘Yes’ or ‘No’ indicating if the Physician listed in that row is your facility’s UNOS Primary Physician.

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PEDIATRIC LIVER TRANSPLANT PROGRAM INFORMATION

Questions in this section that refer to “my,” “your,” “my facility’s” or “your facility’s program” all refer to your facility’s own pediatric liver transplant program (not the Blue Distinction Centers for Transplants program).

Questions 43 through 47 pertain to your facility’s Pediatric (17 years and younger) Liver Transplant Program.

43. Is the pediatric liver transplant program’s primary contact different than the primary contact reported in Question 1?
   - YES
   - NO

   43a. Pediatric Liver Transplant Program’s Primary Contact
       - Name:
       - Title:
       - Phone:
       - E-mail:

44. Is your pediatric liver transplant program currently certified by and in good standing with Centers for Medicare & Medicaid Services (CMS)?
   - YES
   - NO

   If NO, please explain.

45. Does your pediatric liver transplant program meet United Network for Organ Sharing (UNOS) guidelines (as outlined in the UNOS policy and by-laws) and is it currently in good standing with UNOS?
   - YES
   - NO

   If NO, please explain.

Transplant Surgeon and Physician Information
46. Please complete the following table for all transplant surgeons who actively perform pediatric liver transplant procedures at your facility.

The instructions for completing the table include:
- **Column A**: Please enter Surgeon's first name.
- **Column B**: Please enter Surgeon's last name.
- **Column C**: Please enter Surgeon's National Provider Identifier (NPI) number. The NPI information can be obtained online in a searchable database available at: [http://npidb.org/npi/](http://npidb.org/npi/)
- **Column D**: Selecting ‘Yes’ in this column indicates the Surgeon is board certified (or in the process of becoming board certified) by the American Board of Surgery or equivalent such as the American Osteopathic Board of Surgery and/or Royal College of Physicians and Surgeons of Canada.
- **Column E**: Please select ‘Yes’ or ‘No’ indicating if the Surgeon listed in that row is your facility’s UNOS Primary Surgeon.

<table>
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<th>A</th>
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</thead>
<tbody>
<tr>
<td>Surgeon’s <em>First</em> Name</td>
<td>Surgeon’s <em>Last</em> Name</td>
<td>Surgeon’s Type 1 National Provider Identifier</td>
<td>Board Certified by American Board of Surgery, or Equivalent</td>
<td>Facility’s UNOS Primary Surgeon?</td>
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</tbody>
</table>

47. Please complete the following table for all transplant physicians who actively manage pediatric liver transplant patients at your facility.

The instructions for completing the table include:
- **Column A**: Please enter Physician’s first name.
- **Column B**: Please enter Physician’s last name;
- **Column C**: Please enter Physician’s National Provider Identifier (NPI) number. The NPI information can be obtained online in a searchable database available at: [http://npidb.org/npi/](http://npidb.org/npi/)
- **Column D**: Selecting ‘Yes’ in this column indicates the Physician is board certified in Internal Medicine (or in the process of becoming board certified) by the American Board of Internal Medicine, the American Osteopathic Board of Internal Medicine, or the Royal College of Physicians and Surgeons of Canada.
- **Column E**: Please select ‘Yes’ or ‘No’ indicating if the Physician listed in that row is your facility’s UNOS Primary Physician.

<table>
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<th>D</th>
<th>E</th>
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</thead>
<tbody>
<tr>
<td>Physician’s <em>First</em> Name</td>
<td>Physician’s <em>Last</em> Name</td>
<td>Physician’s Type 1 National Provider Identifier</td>
<td>Board Certified by American Board of Internal Medicine, or Equivalent</td>
<td>Facility’s UNOS Primary Physician?</td>
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<td>No</td>
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</tbody>
</table>
Questions in this section that refer to “my,” “your,” “my facility’s” or “your facility’s program” all refer to your facility’s own adult autologous/ allogeneic bone marrow/ stem cell transplant program (not the Blue Distinction Centers for Transplants program).

Questions 48 through 52 pertain to your facility’s Adult (18 years and older) Autologous/ Allogeneic Bone Marrow/ Stem Cell Transplant Program.

48. Is the adult bone marrow/ stem cell transplant program’s primary contact different than the primary contact reported in Question 1?

☐ YES ☐ NO

48a. Adult Bone Marrow/ Stem Cell Transplant Program’s Primary Contact
Name:
Title:
Phone:
E-mail:

49. Is your facility accredited by the Foundation for the Accreditation of Cellular Therapy (FACT) for adult autologous AND allogeneic bone marrow/ stem cell transplants?

☐ YES ☐ NO

If NO, please explain.

50. Please complete the following table, which asks for volumes of bone marrow/ stem cell transplants performed at your facility. Instructions in the table outline the parameters to use in responding to these questions.

<table>
<thead>
<tr>
<th>Q#</th>
<th>Number of Bone Marrow/ Peripheral Blood Stem Cell (BM/PBSC)/ Cord Blood Transplants</th>
<th>Facility Bone Marrow/ Stem Cell Transplant Population Volume Criteria:</th>
</tr>
</thead>
<tbody>
<tr>
<td>50a</td>
<td>Related Allogeneic BM/PBSC/Cord</td>
<td>Include transplants regardless of whether or not the patient was a Blue Cross and/or Blue Shield member, if ALL of the following criteria are met:</td>
</tr>
<tr>
<td>50b</td>
<td>Unrelated Allogeneic BM/PBSC/Cord</td>
<td>• Transplant was performed at your facility;</td>
</tr>
<tr>
<td>50c</td>
<td>Total Facility Allogeneic (Related &amp; Unrelated) BM/PBSC/Cord Volume</td>
<td>• Transplant was performed during the most recent 12 months; AND</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Patient was at least 18 years old at time of transplant.</td>
</tr>
</tbody>
</table>
51. Please indicate your facility’s Case Mix Score (1-5) from your most recent Report on Transplant Center-Specific Survival Rates prepared by the Center for International Blood and Marrow Transplant Research (CIBMTR).

[ ] 1 [ ] 2 [ ] 3 [ ] 4 [ ] 5 [ ] Not available

*CIBMTR no longer provides Case Mix Scores. Facilities do not need to answer this question. Please leave blank. (Updated 11/15/2016)*

Transplant Physician Information

52. Please complete the following table for all transplant physicians who actively manage adult bone marrow/ stem cell transplant patients at your facility.

The instructions for completing the table include:
- **Column A**: Please enter Physician’s first name.
- **Column B**: Please enter Physician’s last name.
- **Column C**: Please enter Physician’s National Provider Identifier (NPI) number. The NPI information can be obtained online in a searchable database available at: [http://npidb.org/npi/](http://npidb.org/npi/)
- **Column D**: Selecting ‘Yes’ in this column indicates the Physician is board certified in Internal Medicine (or in the process of becoming board certified) by the American Board of Internal Medicine, the American Osteopathic Board of Internal Medicine, or the Royal College of Physicians and Surgeons of Canada.
- **Column E**: Please select ‘Yes’ or ‘No’ indicating if the Physician listed in that row is your facility’s Foundation for the Accreditation of Cellular Therapy (FACT) Director.

<table>
<thead>
<tr>
<th>Physician’s First Name</th>
<th>Physician’s Last Name</th>
<th>Physician’s Type 1 National Provider Identifier</th>
<th>Board Certified by American Board of Internal Medicine, or Equivalent</th>
<th>Facility’s FACT Director?</th>
</tr>
</thead>
<tbody>
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<td>☑ Yes</td>
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<td>☑ No</td>
<td>☑ No</td>
</tr>
</tbody>
</table>

[Add Rows]

|                        |                       |                                                  | ☑ Yes                                                          | ☑ Yes                    |
|                        |                       |                                                  | ☑ No                                                           | ☑ No                     |

**PEDIATRIC BONE MARROW/ STEM CELL TRANSPLANT PROGRAM INFORMATION**

*Questions in this section that refer to “my,” “your,” “my facility’s” or “your facility’s program” all refer to your facility’s own pediatric autologous/ allogeneic bone marrow/ stem cell transplant program (not the Blue Distinction Centers for Transplants program).*

Questions 53 through 57 pertain to your facility’s Pediatric (17 years and younger) Autologous/ Allogeneic Bone Marrow/ Stem Cell Transplant Program.

53. Is the pediatric bone marrow/ stem cell transplant program’s primary contact different than the primary contact reported in Question 1?
53a. Pediatric Bone Marrow/ Stem Cell Transplant Program’s Primary Contact
Name:
Title:
Phone:
E-mail:

54. Is your facility accredited by the Foundation for the Accreditation of Cellular Therapy (FACT) for pediatric autologous AND allogeneic bone marrow/ stem cell transplants?

☐ YES  ☐ NO

If NO, please explain.

55. Please complete the following table, which asks for volumes of bone marrow/ stem cell transplants performed at your facility. Instructions in the table outline the parameters to use in responding to these questions.

<table>
<thead>
<tr>
<th>Q#</th>
<th>Number of Bone Marrow/ Peripheral Blood Stem Cell (BM/PBSC)/ Cord Blood Transplants</th>
<th>Facility Bone Marrow/ Stem Cell Transplant Population Volume Criteria:</th>
</tr>
</thead>
<tbody>
<tr>
<td>55a</td>
<td>Related Allogeneic BM/PBSC/Cord</td>
<td>Include transplants regardless of whether or not the patient was a Blue Cross and/or Blue Shield member, if ALL of the following criteria are met:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Transplant was performed at your facility; AND</td>
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<tr>
<td></td>
<td></td>
<td>• Transplant was performed during the most recent 12 months; AND</td>
</tr>
<tr>
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<td></td>
<td>• Patient was 17 years old or younger at time of transplant.</td>
</tr>
<tr>
<td>55b</td>
<td>Unrelated Allogeneic BM/PBSC/Cord</td>
<td></td>
</tr>
<tr>
<td>55c</td>
<td>Total Facility Allogeneic (Related &amp; Unrelated) BM/PBSC/Cord</td>
<td></td>
</tr>
<tr>
<td>55d</td>
<td>Total Facility Autologous BM/PBSC/Cord</td>
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</tr>
</tbody>
</table>

56. Please indicate your facility’s Case Mix Score (1-5) from your most recent Report on Transplant Center-Specific Survival Rates prepared by the Center for International Blood and Marrow Transplant Research (CIBMTR):

1  2  3  4  5  Not available

*CIBMTR no longer provides Case Mix Scores. Facilities do not need to answer this question. Please leave blank. (Updated 11/15/2016)*

Transplant Physician Information

57. Please complete the following table for all transplant physicians who actively manage pediatric bone marrow/ stem cell transplant patients at your facility.
The instructions for completing the table include:

- **Column A**: Please enter Physician’s first name.
- **Column B**: Please enter Physician’s last name.
- **Column C**: Please enter Physician’s National Provider Identifier (NPI) number. The NPI information can be obtained online in a searchable database available at: [http://npidb.org/npi/](http://npidb.org/npi/)
- **Column D**: Selecting ‘Yes’ in this column indicates the Physician is board certified in Internal Medicine (or in the process of becoming board certified) by the American Board of Internal Medicine, the American Osteopathic Board of Internal Medicine, or the Royal College of Physicians and Surgeons of Canada.
- **Column E**: Please select ‘Yes’ or ‘No’ indicating if the Physician listed in that row is your facility’s Foundation for the Accreditation of Cellular Therapy (FACT) Director.

<table>
<thead>
<tr>
<th>A</th>
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<tbody>
<tr>
<td><strong>Physician’s First Name</strong></td>
<td><strong>Physician’s Last Name</strong></td>
<td><strong>Physician’s Type 1 National Provider Identifier</strong></td>
<td>Board Certified by American Board of Internal Medicine, or Equivalent</td>
<td>Facility’s FACT Director?</td>
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</tbody>
</table>
The following set of questions pertains to contact information for your facility’s transplant program coordinators, admissions, billing, travel and lodging. *(Informational and Optional)*

Please note that these questions apply to both adult and pediatric facilities applying for the transplants program designation.

1. Complete the following table to include all of your Program(s) Transplant Coordinators for each transplant program for which your facility has applied:

<table>
<thead>
<tr>
<th>First Name</th>
<th>Last Name</th>
<th>Credentials</th>
<th>Phone Number</th>
<th>Fax Number</th>
<th>Email</th>
<th>Coordinator Position</th>
<th>Transplant Program(s)</th>
</tr>
</thead>
<tbody>
<tr>
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<td></td>
<td>Pre Transplant</td>
<td>Adult Heart</td>
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<td>Post-Transplant</td>
<td>Adult Lung</td>
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<td></td>
<td>New Patient Review</td>
<td>Adult Liver (Deceased)</td>
</tr>
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<td>Utilization Review</td>
<td>Adult Liver (Living)</td>
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<td>Social Services</td>
<td>Adult Pancreas</td>
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<td>Adult BMT</td>
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<td>Pediatric Heart</td>
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<td>Pediatric Liver</td>
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<td></td>
<td>Pediatric BMT</td>
</tr>
</tbody>
</table>

2. Please provide your facility’s Admissions and Billing Contacts.

2a. Your facility’s Referral contact who will receive the Blue Distinction Centers for Transplants Preauthorization Form.
   - Referral Contact Name *(First Name Last Name):*
   - Phone Number:
   - Fax Number:
   - Email Address:

2b. Your facility’s Admitting contact who will complete the Blue Distinction Centers for Transplants Admission Notification Form.
   - Admitting Contact Name *(First Name Last Name):*
   - Phone Number:
   - Fax Number:
   - Email Address:

2c. Your facility’s Billing contact who will manage the Blue Distinction Centers for Transplants billing for all providers.
   - Billing Contact Name *(First Name Last Name):*
   - Phone Number:
   - Fax Number:
3. Please provide the following travel and lodging information available to your facility’s transplant patients and families.

3a. Airport Services closest to your facility
   Airport Name:
   Driving Distance from Airport to Facility:

3b. Air/ Ground Ambulance Services used by your facility
   Air Ambulance Company Name:
   Phone Number:

   Ground Ambulance Company Name:
   Phone Number:

3c. Lodging (hotel/ motel/ other) closest to your facility
   Hotel/ Motel/ Other Name:
   Phone Number:
   Discounted Rate/Night:

   Hotel/ Motel/ Other Name:
   Phone Number:
   Discounted Rate/Night:

   Hotel/ Motel/ Other Name:
   Phone Number:
   Discounted Rate/Night:
Attestation for Provider Survey Participation
Blue Distinction® Centers for Specialty Care Program

By submitting its response to this Provider Survey for consideration as a participant in this Blue Distinction Centers for Specialty Care Program (the “Program”), and, if accepted by BCBSA, as a condition to any designation and participation in the Program, this facility (“Facility”) represents and agrees as follows:

1. All information that Facility provides in its response to BCBSA’s Provider Survey for consideration as a participant in this Program (including information provided in Facility’s initial response, as well as any additional materials submitted throughout the evaluation and appeal process for this Provider Survey cycle) is and will be true and complete, as of the date Facility provides such information to BCBSA. Facility will advise BCBSA immediately of any material change in such information during this Provider Survey process, and if Facility is designated as a Blue Distinction Center under this Program, for the duration of such designation.

2. BCBSA may share Facility’s individual Provider Survey responses (“Raw Data”) and results (“Scores”) with BCBSA’s member Plans and, pursuant to a confidentiality agreement, member Plans’ current and prospective accounts, for purposes of evaluation, care management, quality improvement, and member Plans’ design of customized products and networks. BCBSA may combine Facility’s Raw Data and Scores together with other facilities’ data to create aggregate information for public dissemination, provided that such aggregate information will not identify Facility by name, and will not contain any Protected Health Information (“PHI”), as defined under the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations (45 C. F. R. Parts 160-164). Hospital’s Raw Data and Scores will not be publicly disseminated beyond the extent permitted above without Facility’s prior written consent, unless required by law (e.g., subpoena).

FACILITY, by the signature below of its duly authorized officer and by submitting its response to this Provider Survey agrees to the terms above and represents and agrees that the statements above are accurate.

FACILITY attests and agrees:

Facility Name: ________________________________________________________

By its duly authorized Officer:

Enter Officer’s Name: ________________________________

Enter Officer’s Title: ________________________________

Date: __________