Blue Cross Blue Shield Blue Care Network of Michigan

OSS/EFT New Provider Enrollment

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 form, otherwise processing will be delayed.
2. Enter all information online; press the tab key  after each entry to move from field to field.

- **Providers and Facilities - Please to be sure to include:**
  - From (Insert name of contact person)
  - Date (MM/DD/YYYY)
  - National Provider Identifier (NPI)
    (Only submit one NPI per application. Multiple NPI's, submit multiple applications.)
    - Individual Provider (Type 1) or
    - Group (Type 2) or
    - Facilities (Type 2)
  - Tax identification number (must include a copy of your IRS tax identification document)
  - Medicare number

If you have questions on how to complete this form please contact provider enrollment at (800) 822-2761.

When you complete this form please fax it to: 866-900-0250

FAX COVER SHEET FOR DOCUMENTS

IMPORTANT: Attach this page to the top of your document to avoid processing delays.

Fax To: 866-900-0250 PEDM

From:

Date:

(Only submit one NPI per application. Multiple NPI's, submit multiple applications.)

Form Number: 14635

Type 1 NPI:

Type 2 NPI:

Tax Identification Number:

Blue Cross Blue Shield Blue Care Network of Michigan

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

OOS/EFT NEW PROVIDER ENROLLMENT

Type 1 National Provider Identifier	Type 2 National Provider Identifier	Tax Identification Number

This enrollment form is only to be used for enrollment into the Electronic Funds Transfer (EFT) of Medicare cross over claim payments. Please indicate your provider type. If your provider type is not a selection, enter your information in the area identified as *"Other"*. If you have questions regarding the completion and submission of this form please contact Provider Enrollment at 800-822-2761.

Section 1: Demographic Data

*denotes a required field

*Provider (d.b.a. name) / Practitioner name

*Medicare number

*What type of proivder are you? Check all that apply.

Facilities:

- ☐ Ambulatory Infusion Center
- ☐ Ambulatory Surgery Facility
- ☐ End-Stage Renal Disease
- ☐ Federally Qualified Health Center
- ☐ Home Health Care
- ☐ Home Infusion Therapy
- ☐ Hospice
- ☐ Hospital
  - ☐ Specialty: _____
- ☐ Long-Term Acute Care Hospital
- ☐ Outpatient Physical Therapy Facility
- ☐ Outpatient Psychiatric Care Facility
- ☐ Psychiatric Residential Treatment Facility
- ☐ Rural Health Clinic
- ☐ Skilled Nursing Facility
  - ☐ Swing Beds ☐ Yes ☐ No
- Substance Abuse Facility
  - ☐ Outpatient ☐ Residential
- Other: _____

Ancillary Providers:

- ☐ Ambulance
- ☐ Freestanding Radiology Center
- ☐ Optician/Optometric Supplier
- ☐ Orthotic Supplier
- ☐ Independent Diagnostic Testing Facility
- ☐ Professional Group (Practitioners)
- ☐ Prosthetic and Orthotic Supplier
- ☐ Other: _____
- ☐ Urgent Care
- ☐ Vision/Hearing
- ☐ Prosthetic Supplier

Professional Practitioners:

- ☐ MD ☐ DC ☐ DO ☐ DPM
- ☐ PT ☐ DMD ☐ OT ☐ NP
- ☐ Specialty: _____
- ☐ Other: _____
- ☐ *Date of birth: _____

Section 2: EIN / SSN Tax information

*denotes a required field

*EIN Tax ID number: _____	*SSN (Practitioner only): _____
*EIN / Tax name as indicated on Internal Revenue Service document	
*Tax exempt / Fiscal year end	☐ Yes ☐ No F.Y.E. Date: _____

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Type 1 National Provider Identifier	Type 2 National Provider Identifier	Tax Identification Number

Section 3: Address Information

*denotes a required field

Primary office address		
*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	

Payment / Remit address		
Street address		
City	State	ZIP code

Mailing address		
Street address		
City	State	ZIP code

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	

Section 4: Application signature

*denotes a required field

I certify that the information contained in this application is true and complete.

*Authorized signature	*Signature / Title	*Date