Instructions for fax cover sheet

We cannot accept handwritten forms. Do not hand write anywhere on the forms, otherwise processing will be delayed.

To ensure forms are processed timely, please adhere to the following instructions:

Enter all information on-line; press the tab key 

after each entry to move from field to field.

- For individual practitioners
  - From (Insert name of contact person)
  - Date (MM/DD/YYYY)
  - Type 1 National Provider Identifier

Instructions for document submission

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 1-866-791-3725. 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).

Please complete the following:

1. **Complete a Signature Document for your Provider Type**
2. **Please submit all required documentation with your enrollment application. The required documentation for your enrollment can be found at: https://www.bcbsm.com/providers/join-the-blues-network/join-provider-network.html**
3. **Please include CAQH ID**
4. **Do not submit your BCBSM application until you have enrolled with CAQH first**

Questions? Call 1-800-822-2761

FAX COVER SHEET FOR DOCUMENTS

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

Fax To: 866-791-3725 Provider Enrollment

From:

Date:

Form Number: 18140

Type 1 NPI:

State License Number:

Blue Cross Blue Shield Blue Care Network of Michigan

BCBSM/CAQH Supplemental Enrollment Form

State License Number	Type 1 National Provider Identifier	

Please complete this form after you have been approved with CAQH. Your **CAQH ID** is required to process this application for enrollment.

Note: You are required to complete and maintain a credentialing application through the Council for Affordable Quality Healthcare at https://proview.caqh.org/pr. In order for your managed care affiliation request to be processed you must **complete your CAQH application within 14 calendar days**. If you have already completed the CAQH application, your attestation must be up to date. If your CAQH application is not complete or if your attestation is expired after 14 calendar days, your request will be closed, and you will need to re-apply using the Practitioner Change Form.

Section 1: Demographic data

* denotes a required field

*First Name	
*Middle Name	
*Last Name	
***CAQH ID**	

Section 2: Requested Networks

You will be notified of your enrollment status when the process is complete.
BCBSM/ BCN does not permit retroactive effective dates.

BCBSM/ BCN Requested Networks	
☐ Traditional – Participating	☐ Traditional – Non Participating
☐ Medicare Plus Blue SM PPO	☐ TRUST PPO
☐ Medicare Supplemental	☐ BCN Commercial
☐ BCN Advantage SM HMO	

Section 2A: Internet Claims Tool

If you would like to submit electronic claims through our provider Web portal (webDENIS), complete section 6 and section 7.

Check the payers and remittance report you would like to sign up for							
BCBSM	BCN	BCBSM Medicare Advantage	Medicare DME	Medicare	Medicaid	Commercial	Electronic Remittance
☐	☐	☐	☐	☐	☐	☐	☐
Internet browser and version							
Hardware and Operating system							

Blue Cross Blue Shield Blue Care Network of Michigan

BCBSM/CAQH Supplemental Enrollment Form

State License Number	Type 1 National Provider Identifier	

Section 3: Provider Secured Services – WEB DENIS

* denotes a required field

Doing business electronically saves your office time and money. We encourage you to sign up for Provider Secured Services, a complimentary service for BCBSM/ BCN participating providers that allows you to view patient eligibility, track claims and much more on-line. Begin the process by completing the information in the section below.

Authorized Web Access Administrator
Provide the name and contact information of the person who is the authorized Web Access Administrator with delegated authority to manage all access to protected health information and group practitioner records using provider secured (Web) self-services.

*Name	*Title
*Telephone Number	*E-mail address
*Does the individual named above currently use Provider Secured Services (webDENIS)?	☐ Yes ☐ No
*If yes, indicate the individual's Provider Secured Services user ID.	*User ID

Provider Secured Services Access
Complete the section below for individual(s) that do not have an existing Provider Secured Services (webDENIS) log-in ID. Only check the minimum necessary features for each user listed below.

*Name (full legal name of each user) *Telephone Number and *E-mail address	Eligibility Coverage	Claims Tracking	BCN PCP Claims Summary	Provider Claim Correction	Internet Claims Tool
1. *Name	☐	☐	☐	☐	☐
*Telephone	*E-mail Address				
2. *Name	☐	☐	☐	☐	☐
*Telephone	*E-mail Address				
3. *Name	☐	☐	☐	☐	☐
*Telephone	*E-mail Address				
4. *Name	☐	☐	☐	☐	☐
*Telephone	*E-mail Address				

The authorized signer agrees that he/ she has the company's designated authority to request and maintain minimum necessary Web access and is responsible for complying with all terms and conditions contained within the Provider Secured Service Use and Protection Agreement.

*Authorized Signature	*Date

Complete the Provider Secured Service Use and Protection Agreement and return with the application.

If you have additional user names, please list and attach separately with access features denoted.

State License Number	Type 1 National Provider Identifier	

Section 4: Application signature

Have you ever been convicted of, pled guilty to, or nolo contendere to any felony?

☐ No
☐ Yes (Insert nature of offenses)

In the past ten years have you been convicted of, pled quilty to, or pled nolo contendere to any misdemeanor (excluding minor traffic violations) or been found liable or responsible for any civil offense that is reasonably related to your qualifications, competence, function, or duties as a medical professional, or for fraud, an act of violence, child abuse or a sexual offense or sexual misconduct?

☐ No
☐ Yes (Insert nature of offenses)

In the past ten years, has any professional corporation, partnership, limited liability company or any other such entity in which you own an equity interest (directly or indirectly) and/or serve any management or leadership function (including, but not limited to, acting as a manager, board member, director, or executive) been convicted of, pled guilty to, or pled nolo contendere to any misdemeanor or been found liable or responsible for any civil or criminal offense?

☐ No
☐ Yes (Insert nature of offenses)

I certify that the information contained in this application is true and complete. I will notify Blue Cross and BlueShield of Michigan and Blue Care Network immediately in writing of changes affecting this data. If I am a practitioner in training, I will not report services that are related to my training program and rendered at the address from which I am training. Should I re-enter training, I will notify BCBSM and BCN.
In addition, the authorized signer agrees that he/she has the company's designated authority to request and maintain minimum necessary Web access and is responsible for complying with all terms and conditions contained within the Provider Secured Services Use and Protection Agreement.

For providers applying to be Traditional non-participating providers, the authorized signer agrees on behalf of itself and the provider on whose behalf the authorized signer is acting, to adhere to BCBSM's Billing Guidelines for Non-Participating Providers. These Guidelines include, without limitation, the requirement to permit BCBSM or its designee physical access to the provider's premises to review and/or copy for any permissible purpose any and all medical and billing records submitted by the provider or its billing agent, and the requirement that the provider accept BCBSM's payment as payment in full for services rendered to a BCBSM member when the provider has indicated that it will accept assignment of payment on the member's behalf, will participate with BCBSM on a particular claim, or has otherwise indicated that he/she wishes to receive payment directly from BCBSM and, with the exception of any applicable deductibles, co-payments, or co-insurance amount, not balance bill the member for the difference between BCBSM's payment and the provider's charged amount.

When Completed

*Print or Type Name	*Signature/Title	*Date