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 online; 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 NPI (National Provider Identifier)
  - State license number
  - When adding an individual to an existing group, be sure to fax a group change form

- **For allied providers**
  - From (Insert name of contact person)
  - Date (mm/dd/yyyy)
  - Type 2 NPI (National Provider Identifier)
  - Tax identification number

- **For professional group practices and facilities**
  - From (Insert name of contact person)
  - Date (mm/dd/yyyy)
  - Type 2 NPI (National Provider Identifier)
  - Tax identification number

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 **1-866-900-0250**. 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.)

Questions? Call 1-800-822-2761

FAX 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:

Form Number: 10576

Type 1 NPI:

Type 2 NPI:

State License Number:

Blue Cross Blue Shield Blue Care Network of Michigan

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

NEW PRACTITIONER ENROLLMENT FORM

State license number	Type 1 National provider identifier	Type 2 National provider identifier

Please complete this form if you are an MD, DO, DC, DPM, DMD/DDS (board certified oral surgeon only), independent physical therapist, independent occupational therapist or independent speech language pathologist applying to Blue Cross Blue Shield of Michigan/Blue Care Network for the first time.

Note: You are required to complete and maintain a credentialing application through the Council for Affordable Quality Healthcare® at http://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 a 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 reapply using the Practitioner Change form.

Section 1: Demographic Data

*denotes a required field

*First name	
Middle name	
*Last name	
Suffix	☐II ☐III ☐IV ☐Jr. ☐Sr.
*What type of provider are you?	☐MD ☐DO ☐DC ☐DPM ☐DMD ☐DDS ☐IPT ☐IOT ☐ISLP
*County where your primary address is located	
*Degree	
*Date of birth	
Gender	☐Male ☐Female
Preferred salutation	☐ Dr. ☐Ms. ☐Mrs. ☐Mr. ☐Miss

Race/Ethnicity

- ☐ White/Caucasian
- ☐ Black or African American
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Chinese/Chinese-American
- ☐ Filipino
- ☐ Japanese/Japanese-American
- ☐ Korean
- ☐ Vietnamese
- ☐ Native Hawaiian or other Pacific Islander
- ☐ Mexican/Mexican-American
- ☐ Hispanic/Latin American
- ☐ Arab
- ☐ Other Race
- ☐ Assyrian/Chaldean
- ☐ Other Asian
- ☐ Multiracial
- ☐ Not Disclosed

If registered with CAQH, CAQH ID number	

NEW PRACTITIONER ENROLLMENT FORM

State license number	Type 1 National provider identifier	Type 2 National provider identifier

Section 2: Change EIN/Tax information

Note: You must include IRS Form 147c or IRS Tax Coupon as an attachment.

*Social Security number	
*Is your EIN/Tax ID number the same as your SSN?	☐ Yes ☐ No (If no, enter Tax ID number below
EIN/Tax number	
EIN/Tax Name as indicated on IRS document	
*Tax exempt	☐ Yes ☐ No
Medicare/PTAN number:	

If you would like to bill with your Type 2 NPI (National Provider Identifier) representing your incorporated individual business, you must **also** complete a New Group Enrollment form to register this entity as a group.

Section 3: Primary specialty

*denotes a required field

*Specialty	
If your specialty is Adolescent Medicine, Family Medicine, Geriatric Medicine - Family Practice, Geriatric Medicine, General Practice, Internal Medicine, Pediatrics, Public Health / General Preventive Medicine, or Preventive Medicine; are you functioning as a: ☐ Primary Care Physician (PCP) or a ☐ Specialty Care Physician (SCP)	
*Board certified (MD, DO, DMD, DPM DDS only)	☐ Yes ☐ No
*Board eligible (MD, DO, DMD, DPM, DDS only)	☐ Yes ☐ No
*Do you practice exclusively in a hospital setting? If ***yes***, Section 1 of CAQH must be updated to reflect hospital based status	☐ Yes ☐ No
*Residency Completed?	☐ Yes ☐ No
*Residency Completion date?	

State license number	Type 1 National provider identifier	Type 2 National provider identifier

Section 4: Requested networks

You will be notified of your status and the effective dates of affiliation in BCBSM and BCN managed care networks after credentialing for the networks is completed and BCBSM and BCN has countersigned your affiliation agreements. **Important: Along with this application, it is necessary to complete and submit the signature document appropriate for your provider type. For each network you wish to participate in, be sure to place a check mark by the appropriate affiliation agreement, sign the signature document, and submit it along with this form.**

BCBSM and BCN do not permit retroactive effective dates in managed care networks.

If you are a specialist billing with a Type 2 NPI, BCN contracts with the Group Practice. Please follow the instructions on the website for Professional Group Enrollment.

Select networks you are applying to:

Provider Type	Eligible Networks for Provider Type	
Doctor of Medicine Doctor of Osteopathy	☐ Traditional-Participating ☐ Traditional-Nonparticipating ☐ Medicare Advantage℠ PPO	☐ TRUST PPO ☐ Blue Preferred Plus ☐ Vision/Hearing (if applicable)
Podiatrist Oral Surgeon	☐ Traditional-Participating ☐ Traditional-Nonparticipating	☐ Medicare Advantage℠ PPO ☐ Blue Preferred Plus ☐ TRUST PPO
Chiropractor Independent Physical Therapist Independent Occupational Therapist	☐ Traditional-Participating ☐ Traditional-Nonparticipating ☐ Medicare Advantage℠ PPO	☐ BCN Commercial ☐ Blue Preferred Plus ☐ TRUST PPO ☐ BCN Advantage℠ HMO
Independent Speech Language Pathologist	☐ Traditional-Participating ☐ Traditional-Nonparticipating ☐ Medicare Advantage℠ PPO	☐ BCN Commercial ☐ Blue Preferred Plus ☐ TRUST PPO ☐ BCN Advantage℠ HMO

BCN Primary Care Physicians

Select the Network(s) to which you are applying	☐ BCN Advantage℠ HMO	☐ BCN Commercial
Please provide the name of the medical care group and number you wish to join	Medical care group name:	
	Medical care group number:	

State license number	Type 1 National provider identifier	Type 2 National provider identifier

Section 5: Address data

Primary office address (Must be an address where health care services are rendered and may be published in BCBSM and 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	

Payment/Remit address		
Street Address		
City	State	Zip Code

Mailing address		
Street Address		
City	State	Zip Code

Medical Records Request (MRR)		
Street Address		
City	State	Zip Code
Contact Name - First	Middle	Last
Telephone	Fax	Email

State license number	Type 1 National provider identifier	Type 2 National provider identifier

Section 5: Address data *(continued)*

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
Work email address			Preferred method of contact? ☐ Email ☐ US Mail

Additional address - Accessibility

*Handicap accessibility: ☐ Yes ☐ No	*Accessible by bus: ☐ Yes ☐ No

***Primary address - Accessibility**

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

Section 6: Services

All provider services:

☐ In-home visits

If you provide in-home visits, please indicate below if you practice exclusively in the home setting or if you also provide care in an office setting:

- ☐ Acupuncture
- ☐ In-home only
- ☐ In-home and office

☐ Lactation counseling

Occupation Therapist, Physical Therapist, Speech Language Pathologist Services:

Autism service	☐ Add ☐ Remove

Telehealth Services

☐ Telehealth - Audio/Visual ☐ Telehealth - Telephone Only

Blue Cross Blue Shield Blue Care Network of Michigan

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

NEW PRACTITIONER ENROLLMENT FORM

State license number	Type 1 National provider identifier	Type 2 National provider identifier

Section 7: Additional solo practice locations (Must be an address where health care services are rendered and may be published in BCBSM and BCN provider directories)

#1 Street Address		
City	State	Zip Code
Telephone Number	Fax Number	

Additional address - Accessibility

*Handicap accessibility: ☐ Yes ☐ No	*Accessible by bus: ☐ Yes ☐ No

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

#2 Street Address		
City	State	Zip Code
Telephone Number	Fax Number	

Additional address - Accessibility

*Handicap accessibility: ☐ Yes ☐ No	*Accessible by bus: ☐ Yes ☐ No

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

#3 Street Address		
City	State	Zip Code
Telephone Number	Fax Number	

Additional address - Accessibility

*Handicap accessibility: ☐ Yes ☐ No	*Accessible by bus: ☐ Yes ☐ No

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

If you have additional locations, please list and attach separately.

State license number	Type 1 National provider identifier	Type 2 National provider identifier

Section 8: 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 guilty 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 Blue Shield 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.

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.

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