Blue Cross Blue Shield Blue Care Network of Michigan

Group Practice Agency Authorization and Acknowledgement Form

It is understood that Group, its representative, or delegate is responsible for having each group member/individual practitioner execute the Group Practice Agency Authorization and Acknowledgement Form. Group must retain copies of such executed form and provide to BCBSM upon request.

I, as a member of _____
(name of group)

Identified by _____ _____
(National Provider Identifier) *(Group Provider Identification Number)*

have authorized _____
(name of authorized group representative)

Check one or both: ☐ Applies to Traditional (Paragraph 1) ☐ Applies to BCN (Paragraph 2)

I authorize the Group Representative named above to act as my agent contracting with Blue Cross Blue Shield of Michigan (BCBSM) and have given this agent the authority to sign the Blue Cross Blue Shield Michigan Practitioner Traditional Participation Agreement (WP 7669 APR 14, WP 12273 NOV 11, WP 3356 APR 14, WP 11088 JAN 10, or WP 11089 JAN 10), the Blue Cross Blue Shield of Michigan Clinical Licensed Master's Social Worker Participation Agreement (WP 11438 JAN 11), the Blue Cross Blue Shield of Michigan Hearing Specialist Provider Participation Agreement (WP 3376 APR 14) or the Blue Cross Blue Shield of Michigan Vision Specialist Provider Participation Agreement (WP 3392 JAN 14) on my behalf for covered services I provide(d) to BCBSM members, consistent with the terms and conditions of the Agreement. I agree that claims will be submitted only for covered services that are medically necessary and that I personally perform or directly supervise. I also agree that this is a continuing authorization and that information on claims' forms submitted by group representative have the same legal effect as if I had submitted it personally. I understand that I may withdraw this authorization and leave the Group at any time by giving 60 days prior written notice to the Group and to BCBSM. I agree to reimburse BCBSM for any losses that occur because of an action on the part of group representatives that results in an overpayment to the Group for services that I rendered.

Continued

Blue Cross
Blue Shield
Blue Care Network
of Michigan

Group Practice Agency Authorization and Acknowledgement Form continued

I authorize the Group representative named above to act as my agent to contract with Blue Care Network of Michigan (BCN) and its subsidiary corporations, including but not limited to BCN Service Company (BSC), to provide health care services under health benefit products sponsored and/or administered by BCN, BSC or other BCN subsidiaries. By my signature below, I affirm that I am familiar with the "BCN Affiliation Agreement(s)" signed on my behalf by the Group Representative. I agree to be bound by all terms and conditions of such Agreement(s), including applicable Provider Manuals and all amendments and modifications thereto. This includes but is not limited to BCN Member hold harmless requirements; BCN professional qualifications and credentialing standards; BCN fraud, waste and abuse policies; government sponsored health benefit products; and BCN administrative programs. Among these are policies related to quality management, medical management, network management, Member education, Member grievance, claims processing and administration, and clinical and nonclinical performance measurement and improvement. This Acknowledgement shall remain in effect for the term of the "BCN Affiliation Agreement(s)" or until I disaffiliate from Group or from BCN in accordance with termination provisions set forth in the "BCN Affiliation Agreement(s)".

1. _____ _____
Provider's Signature (required) *Individual's National Provider Identifier*

_____ _____
Provider's Name/Degree (print or type) *License Number*

2. _____ _____
Provider's Signature (required) *Individual's National Provider Identifier*

_____ _____
Provider's Name/Degree (print or type) *License Number*

3. _____ _____
Provider's Signature (required) *Individual's National Provider Identifier*

_____ _____
Provider's Name/Degree (print or type) *License Number*

4. _____ _____
Provider's Signature (required) *Individual's National Provider Identifier*

_____ _____
Provider's Name/Degree (print or type) *License Number*

5. _____ _____
Provider's Signature (required) *Individual's National Provider Identifier*

_____ _____
Provider's Name/Degree (print or type) *License Number*

6. _____ _____
Provider's Signature (required) *Individual's National Provider Identifier*

_____ _____
Provider's Name/Degree (print or type) *License Number*