



e-referral Request for Group ID Changes

Please complete electronically

Office/Practice/Group Name: _____

Street address and suite number: _____

City: _____ State: _____ Zip Code: _____

Please provide a Provider Secured Services Login ID that currently has access to e-referral for verification purposes _____

Please add the following providers to my existing e-referral

Provider name (print first name and last name)

10-digit NPI

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please delete the following providers to my existing e-referral

Provider name (print first name and last name)

10-digit NPI

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Authorization for access to e-referral

Provider / Facility Authorized Signature

Do not use a signature stamp on the line above

Date

Type the name of the authorized signer

Signer's title

Telephone number

Fax number

E-mail address

By signing above, I represent and warrant that I have been granted full legal authority, by corporate resolution, appropriate delegated signature authority, or as permitted by a signature authorization policy, to enter into and bind the provider and/or facility group to contracts and agreements and, intending to be legally bound, have executed this agreement on the date listed above.

Fax or mail application to:
Blue Cross Blue Shield of Michigan
53200 Grand River
Mail Code L830
New Hudson, MI 48165
Fax# 1-800-495-0812

Blue Cross Blue Shield of Michigan and Blue Care Network are nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association.