



ADDENDUM "B"
AUTHORIZATION FOR REPRESENTATIVE ACCESS

Provider Secured Services ID Number(s): \_\_\_\_\_
To view an example of updating consecutive Provider Secured Service IDs, place the mouse pointer on an input field above.

This Authorization For Representative Access Form permits you to authorize a billing service, service bureau or TPA to have access to designated information for your individual and/or group provider code(s) (your Authorized Representative).

HIPAA requires when using, requesting or disclosing PHI, covered entities must make reasonable efforts to limit the information to the minimum necessary to accomplish the intended purpose of the use, disclosure or request. Consequently BCBSM requires you identify the level of access necessary for the Authorized Representative to perform the function for which the Authorized Representative was hired.

I hereby authorize \_\_\_\_\_, which is my business associate and Authorized Representative to access the
(Billing Service/Service Bureau, TPA Name)
following information provided via Provider Secured Services, either now or in the future, for both my individual and/or group provider codes(s), which is the minimum information necessary for my business associate to perform the function for which the business associates was hired.

ACCESS REQUEST

Please check the appropriate box below to authorize the level of access that you deem necessary for the above named Authorized Representative to have in order to perform functions on your behalf.

- checkbox All Provider Secured Services eligibility and claim status information available for my provider code(s) below.
checkbox Limited access to Provider Secured Services functions as indicated below
checkbox Eligibility/Benefits Only
checkbox Claims Tracking, Electronic Funds Transfer, and Status

ADD TO PROVIDER TABLE

Identify the BCBSM, Blue Care Network provider codes (professional and/or facility), the Authorized Representative can access:

Table with 2 columns: BCBSM/BCN PROVIDER CODE, TYPE IN CODES/ID TO BE ADDED AND SELECT THE LINE OF BUSINESS IF NEEDED. Rows include 7 or 10-digit Professional Provider Code or NPI Number, Medicare Provider Code, and 5-digit Facility Code (Used on the UB04 Form) or NPI Number.

AUTHORIZATION

(To be completed by Provider's Office only)

The authorization individual whose name appears below is authorized to bind Providers to the terms of this Authorization and, intending to be legally bound, has executed this Authorization to Add BCBSM and/or BCN Provider Codes to Secure Provider Portal/web DENIS on the date set forth below.

If Provider is an individual, the authorization must be signed by the individual provider. If provider is a group practice, the authorization must be signed by the owner or head physician of the group practice. If provider is a hospital, the authorization must be signed by the CEO or the hospital administrator. If a group practice or hospital has delegated signature authority to another individual, that individual may sign the authorization if proof of delegated signature authority is submitted to BCBSM.

Provider/Facility Name Associated with PIN#/Facility/Medicare Code

Date

Name of Authorized Individual

Title of Authorized Individual

Signature of Authorized Individual

Do not use a signature stamp on the line above

Provider Tax ID Number

Provider Mailing Address

Note: If the signatory above contractually represents multiple providers in the business of health insurance billing/inquiry, they must include a printout of all such codes with this Addendum.

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

Contact Name \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_