Instructions for fax cover sheet

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

- 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: 10579

Type 1 NPI:

State License Number:

Blue Cross Blue Shield of Michigan is a nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association.

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PRACTITIONER CHANGE FORM

State license number	Type 1 National provider identifier	

If you are a MD, DO, DC, DPM, DMD/DDS (Board certified oral surgeon only), independent physical therapist, independent occupational therapist or independent speech language pathologist, use this form to:

- Provider Race/Ethnicity Information – Section 1
- Change Medicare/PTAN number, EIN/Tax ID number and/or tax name – Section 2
- Request additional networks – Section 3
- Request to terminate networks – Section 4
- Change BCBSM participation status – Section 5
- BCN PCP changes – Section 6
- Change remit/mailing/medical records address – Section 7
- Change Services – Section 8
- Add/end practice locations – Section 9
- End practitioner's relationship with a group – Section 10
- Change Type 1 NPI – Section 11
- Contact Information – Section 12
- Application Signature – Section 13

The following fields must be changed through the CAQH at https://proview.caqh.org/PO

- First name
- Middle name
- Last name
- Suffix
- Date of birth
- SSN
- Primary address
- Specialty/Board certification

Section 1: Demographic Data

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

Section 2: Change EIN/Tax ID number and/or tax name

Note: If your payment and remittance address changes as a result of your change in EIN Tax ID

- You must also update your payment and remittance address on CAQH
- Include IRS Form 147c or an IRS Tax Deposit Coupon.

EIN/Tax ID number	
EIN/Tax ID name as indicated on internal revenue service document	
Tax exempt: Yes No	Effective date:
Medicare/PTAN number	

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

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PRACTITIONER CHANGE FORM

State license number	Type 1 National provider identifier	

Section 3: Request additional networks

If you are applying for a managed care network, you must complete your **Council for Affordable Quality Healthcare® (CAQH) application within 14 calendar days.** If you have already completed CAQH, 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.

You will be notified of your status and the e fective dates of affiliation in BCBSM and BCN managed care networks after credentialing for the networks is completed and BCBSM and BCN has counter-signed 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 instructions on the website for Professional Group Enrollment.

Select networks you are applying to:

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

Section 4: Termination of networks

Note: If you are terminating all networks, please complete the Practitioner Termination Form.
Requested termination date - The actual date of your termination will be determined based on the provisions in the applicable participation agreements.

BCBSM Networks	Requested termination date
Hearing	Date:
TRUST PPO	Date:
Medicare Advantage SM PPO	Date:
Blue Preferred Plus	Date:
BCN Networks	**Requested termination date**
BCN Commercial	Date:
BCN Advantage SM HMO	Date:
Other	**Requested termination date**
Medicare Supplemental	Date:

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State license number	Type 1 National provider identifier	

Section 5: Change BCBSM participation status

The actual date of your participation status will be determined based on the provisions in the applicable participation agreement.

BCBSM Networks	Requested participation change
Traditional	Non-participating to Participating (include Individual Signature document) Participating to Non-Participating (effective 60 days upon receipt of request)
Vision	Non-participating to Participating (include Individual Signature document) Participating to Non-Participating (effective 60 days upon receipt of request)

Section 6: BCN PCP changes

Are you applying to BCN to be a primary care physician? Yes No

If yes, select network(s) you are appling to: BCN Commercial BCN Advantage SM HMO

Are you currently a PCP requesting to change your medical care group endorsement? Yes No

If yes to either of the above questions, please provide the name of the MCG you wish to join.

MCG name:	MCG number:
Are you currently a PCP requesting to be a specialist?	Yes No

If you are an endorsed specialist, please contact your MCG who will submit your acknowledgment signature document to BCN on your behalf. For more MCG information go to: http://www.bcbsm.com/pdf/bcn_par_mcg_endorsement.pdf

Section 7: Change remit/mailing/medical records address

Payment/Remit address		
Effective date		
Street address		
City	State	Zip Code
Mailing Address		
Effective date		
Street address		
City	State	Zip Code

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PRACTITIONER CHANGE FORM

State license number	Type 1 National provider identifier	

Section 7: Change remit/mailing/medical records address - continued

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

Section 8: Change Services

All Practitioner Services:

In-home visits If adding, please indicate below if you practice exclusively in the home setting or if you also provide care in an office setting: In home only In home and office	Add	Remove
Lactation counseling	Add	Remove

Occupational Therapist, Physical Therapist, Speech Language Pathologist Services:

Autism services	Add	Remove

Telehealth Services:

Telemedicine Offered-audio and visual	Add	Remove
Telemedicine Originating Site	Add	Remove
Real-time on-line visit/e-visit	Add	Remove

Section 9: Add/end Practice Locations

Note: Address details only required if adding a practice location. This must be an address where health care services are rendered and may be published in BCBSM and BCN provider directories.

#1 Address details:

Add this location — **Effective Date:** ____________________

End this location — **Effective Date:** ____________________

Street address		
City	State	Zip Code
Telephone number	Fax number	

Office hours	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Open time							
Close time							

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PRACTITIONER CHANGE FORM

State license number	Type 1 National provider identifier	

Section 9: Add/end practice locations - continued

#2 Address details:

Add this location | **End this location**

Effective Date: ____________________ **Effective Date:** ____________________

Street address		
City	State	Zip Code
Telephone number	Fax number	

Office hours	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Open time							
Close time							

Primary Location

Do you need to change your **primary** location? Yes No

If yes, the change must be made through CAQH at https://proview.caqh.org/PO

Additional Location(s)

Do you need to **add additional** location(s)? Yes No

If yes, include address details when adding a practice location. This must be an address where health care services are rendered and may be published in the BCBSM and BCN provider directories.

If no, and you are only ending a location (other than the primary location), address details are not required.

If you have additional practice locations that you want to add/end, please list and attach separately.

Section 10: End practitioner's relationship with a group

Identify group(s) you are no longer affiliated with as a practitioner.

Group name	Type 2 NPI
Effective date of Termination	Check here if physicians were acting as a BCN PCP

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State license number	Type 1 National provider identifier	

Section 11: Change Type 1 National provider identification

Previous Type 1 NPI	New Type 1 NPI
Reason for change	

Section 12: Contact information

*denotes a required field

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? E-mail US mail

Section 13: Application signature

*denotes a required field

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	*Practitioner signature/Title	*Date