Instructions for fax cover sheet

We cannot accept handwritten forms. To ensure forms are processed timely, please adhere to the following instructions:

1. Do not hand write anywhere on the form, otherwise processing will be delayed.
2. 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/YY)
  - Type 1 NPI National Provider Identifier
  - State license number
  - When adding an individual to an existing group be sure to include your group's Type 2 National Provider Identifier and a group change form
- For allied providers
  - From (Insert name of contact person)
  - Date (MM/DD/YY)
  - Type 2 NPI National Provider Identifier
  - Tax identification number
- For group practices
  - From (Insert name of contact person)
  - Date (MM/DD/YY)
  - Type 2 NPI National Provider Identifier
  - Tax identification number

Instructions for form 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.)
3. You can also mail the completed forms and documentation to:

Provider Enrollment
Blue Cross Blue Shield of Michigan
P.O. Box 217,Southfield Mi, 48034

Questions? Call 1-800-822-2761

Blue Cross Blue Shield Blue Care Network of Michigan

ALLIED PRACTITIONER CHANGE FORM

FAX OR MAIL 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:

Mail to: Provider Enrollment
Blue Cross Blue Shield of Michigan
P.O. Box 217
Southfield, MI 48034

Form Number: 10580

Type 1 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

ALLIED PRACTITIONER CHANGE FORM

State license number	Type 1 National provider identifier	

Please complete this form if you are one of the provider types listed below and applying to Blue Cross Blue Shield of Michigan and Blue Care Network for the first time. Note: If you are an orthotic supplier, prosthetic supplier or prosthetic and orthotic supplier with a facility certification, please complete the Allied Provider Change form.

You (except anesthesia assistants) are required to complete and maintain a credentialing application through the Council for Affordable Quality Healthcare® at http://upd.caqh.org/oas/ 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.

- Provide Race/Ethnicity Information - Section1
- Change 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
- Change remit/mailing address - Section 6
- Add/end practice locations - Section 7
- Change Type 1 NPI - Section 8
- Contact information - Section 9
- Application signature - Section 10

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

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

What type of provider are you?

- ☐ anesthesia assistant
- ☐ audiologist
- ☐ certified nurse practitioner
- ☐ certified nurse midwife
- ☐ certified registered nurse anesthetist
- ☐ hearing aid dealer
- ☐ optometrist
- ☐ orthotic supplier
- ☐ prosthetic supplier
- ☐ prosthetic and orthotic supplier
- ☐ physician assistant

Blue Cross
Blue Shield
Blue Care Network
of Michigan

Nonprofit corporations and independent licensees
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ALLIED PRACTITIONER CHANGE FORM

State license number	Type 1 National provider identifier	

Section 1: Demographic Data

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

Section 2: Change EIN/Tax number

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.

EIN/TAX number	
EIN/TAX name as indicated on the internal revenue service document	
Tax exempt	☐ Yes ☐ No
Effective Date	

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.

Section 3: Request additional networks

If you are applying for a managed care network, you must complete the 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

ALLIED PRACTITIONER CHANGE FORM

State license number	Type 1 National provider identifier	

Section 3: Request additional networks continued

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 counter-signed your affiliation agreements. Important: If applying to participate with Traditional, Vision, Hearing, TRUST PPO, Medicare Advantage PPO, BCN Commercial, BCN Advantage HMO SM ,Blue Preferred Plus, please return an Individual Signature Document for each network.

BCBSM and BCN do not permit retroactive effective dates.

Select networks you are applying to:

Provider Type	Eligible Networks for Provider Type
anesthesia assistant	☐ Traditional ☐ Medicare Advantage PPO ☐ Blue Cross Complete
audiologist	☐ Traditional ☐ Hearing ☐ Medicare Advantage PPO ☐ BCN Commerical ☐ BCN Advantage HMO SM ☐ Blue Cross Complete
optometrist	☐ Traditional ☐ Vision ☐ Medicare Advantage PPO ☐ BCN Commerical ☐ BCN Advantage HMO SM ☐ Blue Cross Complete
certified nurse midwife certified nurse anesthetist	☐ Traditional ☐ Medicare Advantage PPO ☐ BCN Commercial ☐ BCN Advantage HMO SM ☐ Blue Cross Complete
certified nurse practitioner	☐ Traditional ☐ Medicare Advantage PPO ☐ BCN Advantage HMO SM ☐ BCN Commercial ☐ BCN Commercial as a primary care practitioner ☐ Blue Cross Complete Name of Medical Care Group endorsing you as a PCP: Number of Medical Care Group endorsing you as a PCP:
hearing aid dealer	☐ BCN Commercial ☐ BCN Advantage HMO SM ☐ Blue Cross Complete
orthotic supplier prosthetic supplier prosthetic & orthotic supplier	☐ Traditional ☐ Medicare Advantage PPO

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

State license number	Type 1 National provider identifier	

Section 4: Request to terminate networks

Requested termination date - The actual date of your termination will be determined based on the provisions in the applicable Participation Agreements

Select networks you are terminating:

BCBSM networks	Requested termination date
Hearing	☐ Date:
Medicare Advantage PPO	☐ Date:
BCN networks	**Requested termination date**
BCN Commercial	☐ Date:
BCN Advantage HMO℠	☐ Date:
Blue Cross Complete	☐ Date:
Medicare Plus Blue PFFS℠	☐ Date:

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 ☐ Participating to Non-participating (effective 60 days upon receipt of request)
Vision	☐ Non-participating to Participating ☐ Participating to Non-participating (effective 60 days upon receipt of request)

State license number	Type 1 National provider identifier	

Section 6: Change remit/mailing address

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

Mailing address		
Effective date		
Street Address		
City	State	Zip Code

Section 7: Add/remove solo practice locations

#1

☐ Add this location Effective date:

☐ Add this location Effective date:

Street Address		
City	State	Zip Code
Telephone Number	Fax Number	

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

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

Do you provide 24/7 coverage at this location? ☐ Yes ☐ No

ALLIED PRACTITIONER CHANGE FORM

State license number	Type 1 National provider identifier	

Section 7: Add/remove solo practice locations continued

#2

☐ Add this location — Effective date:

☐ Add this location — Effective date:

Street Address

City	State	Zip Code

Telephone Number	Fax Number

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

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

Do you provide 24/7 coverage at this location? ☐ Yes ☐ No

#3

☐ Add this location — Effective date:

☐ Add this location — Effective date:

Street Address

City	State	Zip Code

Telephone Number	Fax Number

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

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

Do you provide 24/7 coverage at this location? ☐ Yes ☐ No

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

State license number	Type 1 National provider identifier	

Section 8: Change Type 1 National provider identifier

Previous Type 1 NPI	
New Type 1 NPI	
Reason for change	

Section 9: 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
Email	Preferred method of contact? ☐ Email ☐ US Mail **Click here for explanation**

Section 10: 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.

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

When Completed