Blue Cross
Blue Shield
Blue Care Network
of Michigan

FAX OR MAIL COVER SHEET FOR DOCUMENTS

IMPORTANT: Attach this page to the top of your documents 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: 10581

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

Practitioner Termination Form

State license number	Type 1 National provider identifier	

By executing this form, you are requesting Blue Cross Blue Shield of Michigan and Blue Care Network to terminate all your current networks and group affiliations. Upon completion of this request, you will no longer be able to bill BCBSM or BCN for services rendered to our subscribers and members.

Requested termination date: _____ Where applicable, the actual termination date will be determined based on the execution provisions in the applicable participation/affiliation agreement(s).

Reason for termination:

Contact information: *denotes a required field

Note: Please provide the name and contact information of a person who can answer questions about information in this application.

*First name	*Last name
*Phone number	Fax number
E-mail	Preferred method of contact? ☐ E-mail ☐ U.S. Mail

Provider Secured Services (web-DENIS) and Internet Claim Tool

Complete the information below to update existing provider portal Web IDs to reflect this practitioner termination.	
Does the individual named above currently use Provider Secured Services (web-DENIS)?	☐ Yes ☐ No
Does this practitioner send claims through BCBSM's Internet Claim Tool?	☐ Yes ☐ No

Practitioner's Signature _____ Print or Type Name _____ Date _____

When Completed