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 forms, 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 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 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

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: 10583

Type 2 NPI:

Tax Identification Number:

	Type 2 National provider identifier	Tax Identification Number

Please complete this form if you are an ambulance, clinical independent laboratory, durable medical equipment supplier, optician/optometric supplier, orthotic, prosthetic, prosthetic and orthotic supplier (with a facility accreditation), urgent care center or vaccine pharmacy applying to Blue Cross Blue Shield of Michigan and Blue Care Network for the first time.

Note: If you are an orthotic, prosthetic, prosthetic and orthotics supplier with an individual certification, please complete the New Allied Practitioner Enrollment form.

Medicare approved independent diagnostic testing facilities, ambulatory surgical facilities and physiological laboratories can only apply to Medicare Plus Blue PFFS SM

Section 1: Demographic data

*denotes a required field

* Provider name	
* What type of provider are you?	☐ Ambulance ☐ Clinical independent laboratory ☐ Durable medical equipment supplier ☐ Optician/optometric supplier ☐ Orthotic supplier ☐ Prosthetic supplier ☐ Prosthetic and orthotic supplier ☐ Vaccine pharmacy ☐ Medicare-approved independent diagnostic testing facility – only eligible to enroll in Medicare Plus Blue PFFS SM (check one): ☐ MRI ☐ Mammography screening center ☐ Mobile X-ray unit ☐ Nuclear medicine ☐ Radiology Medicare-approved ambulatory surgical facility - only eligible to enroll in Medicare Plus Blue PFFS SM Medicare-approved physiological laboratory - only eligible to enroll in Medicare Plus Blue PFFS SM ☐ Urgent care center Open for business? ☐ Yes; Date opened: ☐ No; Date to open for business:
*County where your primary address is located	

	Type 2 National provider identifier	Tax identification number

Section 2: EIN/Tax information

*denotes a required field

* EIN/Tax ID number	
* EIN/Tax name as indicated on Internal Revenue Services document	
* Tax exempt	☐ Yes ☐ No

Section 3: Requested networks

You will be notified of your status and the effective dates of affiliation in BCBSM and BCN's managed care networks after credentialing for the networks is completed and BCBSM and BCN have countersigned your Affiliation Agreements**. Important:** If applying to participate with Traditional, Vision, TRUST PPO, Medicare Advantage PPO, BCN Commercial, BCN Advantage HMO SM, Blue Preferred Plus, please return a Signature Document for each eligible network.

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

Select networks you are applying to:

BCBSM networks	**Requested networks**
Traditional	☐ Participating ☐ Nonparticipating Requested effective date: Eligible provider types: Ambulance, clinical independent laboratory durable medical equipment supplier, orthotic, prosthetic, prosthetic and orthotic supplier, urgent care center, vaccine pharmacy
Medicare Advantage PPO	☐ Eligible provider types: Ambulance
Vision	☐ Participating ☐ Nonparticipating Requested effective date: Eligible provider types: Optician/optometric supplier
TRUST PPO	☐ Eligible provider types: Vaccine pharmacy
BCN networks	**Requested networks**
BCN Commercial	☐ Eligible provider types: Ambulance, vaccine pharmacy
BCN Advantage HMO SM	☐ Eligible provider types: Ambulance
Blue Preferred Plus	☐ Eligible provider types: Ambulance

If you do not want to enroll with BCBSM/BCN, but wish to register your information for Medicare Plus PFFS SM **only** check here ☐

	Type 2 National provider identifier	Tax identification number

Section 4: Professional ID's/Required documentation

Provider type	Professional ID
Ambulance license number (ground) (attach copy)	
Ambulance FAA number (air) (attach copy)	
DME PTAN number (attach copy of medicare approval letter)	
Laboratory CLIA number (attach copy of the certificate)	
Vaccine pharmacy (attach copy of BCBSM pharmacy network administration approval letter)	
Orthotic, prosthetic, prosthetic and orthotic supplier (attach a copy of accrediting organization certification)	
Medicare-approved independent diagnostic testing facility PTAN number (attach copy of Medicare approval letter)	
Medicare-approved ambulatory surgical facility PTAN number (attach copy of Medicare approval letter)	
Medicare approved physiological laboratory PTAN number (attach copy of Medicare approval letter)	

Section 4A: Urgent Care Center (UCC) Required Information

UCC Medical Director Name	Medical Director Michigan Professional License
UCC Medical Director Type 1 NPI	Is the Urgent Care Center **100%** owned by a hospital? ☐ YES ☐ NO
If Yes is checked please provide: Hospital Name: _____ Hospital Address: _____	
UCC Medical Director Attestations I attest that all personnel practicing in the Urgent Care Center are appropriately licensed in Michigan. I attest that during the prior five year period, there is an absence of fraud and illegal activities against the urgent care center. Medical Director Signature: _____ Date: _____	

	Type 2 National provider identifier	Tax identification number

Section 5: Address data

*denotes a required field

Primary office address (must be an address where health care services are rendered and may be published in BCBSM/BCN provider directories)		
*Street address		
*City	*State	*ZIP code
Primary telephone number must be a phone number patients can call to make an appointment.		
*Primary telephone number	Fax number	

Payment/Remit address (if different from your primary address)		
Street address		
City	State	ZIP code

Mailing address (if different from your primary address)		
Street address		
City	State	ZIP code

Primary address – Accessibility	
* Handicap accessibility ☐ Yes ☐ No * Accessible by train ☐ Yes ☐ No * Accessible by bus ☐ Yes ☐ No	
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	Fax number
E-mail	Preferred method of contact? ☐ E-mail ☐ U.S. Mail **Click here for explanation**

Primary address – office hours							
Office hours	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Open time							
Close time							

	Type 2 National provider identifier	Tax identification number

Section 6: Provider secured services – web-DENIS

*denotes a required field

Doing business electronically saves your office time and money. We encourage you to sign up for Provider Secured Services, a free service for BCBSM and BCN participating providers that allows you to view patient eligibility, track claims, and much more online. Begin the process by completing the information in the section below:

Authorized Web Access Administrator
Provide the name and contact information of the person who is the authorized Web Access Administrator with delegated authority to manage all access to protected health information and group practitioner records using provider secured (web) self services.

*Name (Type or print)	*Title
*Telephone	*E-mail
*Does the individual named above currently use Provider Secured Services (web-DENIS)?	☐ Yes ☐ No
If yes, indicate the individual's Provider Secured Services user ID.	User ID

Provider Secured Services Access
Complete the section below for individuals that do not have an existing Provider Secured Services (web-DENIS) login ID. Only check-off the minimum necessary features for each user listed below.

*Name (full legal name of each user) *Telephone Number & E-mail	Eligibility Coverage	Claims Tracking	BCN PCP Claims Summary	Provider Claim Correction	Internet Claims Tool
1. *Name	☐	☐	☐	☐	☐
*Telephone Number	E-mail				
2. *Name	☐	☐	☐	☐	☐
*Telephone Number	E-mail				
3. *Name	☐	☐	☐	☐	☐
*Telephone Number	E-mail				
4. *Name	☐	☐	☐	☐	☐
*Telephone Number	E-mail				
5. *Name	☐	☐	☐	☐	☐
*Telephone Number	E-mail				

The authorized signer agrees that he/she has the company's designated authority to request and maintain minimum necessary Web access and is responsible for complying with all terms and conditions contained within the Provider Secured Service Use and Protection Agreement.

*Authorized Signature	*Date

Complete the Provider Secured Service Use and Protection Agreement and return with this application. If you have additional user names, please list and attach separately with access features denoted.

	Type 2 National provider identifier	Tax identification number

Section 7: Provider secured services – Provider Enrollment and Change Self Service

Sign-up for 'Provider Enrollment and Change Self Service'

Provider Secured Service (web-DENIS) users can sign-up for access to Provider Enrollment and Change Self-Service. This service provides users the ability to perform online group information updates including: adding and removing practitioners, managing service locations, and enrolling new practitioners for your group. It also allows you to check the status of tasks in progress and see the current information related to your group. Users can have:

Provider Enrollment and Change Basic Self-Service Access: Allows designated/authorized Group Administrator to maintain your Group information.

Provider Enrollment and Change Full Self-Service Access: Allows designated/authorized Group Administrator to not only maintain Group information but also allows to enroll & add new practitioners to your group.

Provider Enrollment and Change Self Service Eligibility Requirements:

1) Must have and identify Type 2 National Provider Identifier (NPI(s))
2) Must complete Authorized Web Access Administrator section 7 (above)
3) Must have a current web-DENIS secure portal user ID. If not, must complete Provider Secured Services Access section 7, including the use and protection agreement form (link)
4) Must complete Addendum G to obtain access to update group information

AUTHORIZED SELF SERVICE REQUEST

I hereby authorize the users listed below to access Provider Enrollment and Change Self Service. I understand, acknowledge and attest that these users have authority to maintain practitioner and provider group enrollment records for all BCBSM Provider codes currently associated with the user as well as any new Provider codes assigned as a result of this application. I understand that I can verify which provider codes are associated with a particular User ID by having the user click on the drop-down list of Provider Codes in the Professional and Facility Claims Tracking tool.

Name (Type in the full name of each user)	Telephone Number and Extension	Web-DENIS ID	Provider Enrollment and Change Self Service Basic Access	Provider Enrollment and Change Self Service Full Access	For BCBSM Use Only
			☐	☐	
			☐	☐	
			☐	☐	
			☐	☐	
			☐	☐	

Blue Cross Blue Shield Blue Care Network of Michigan

Nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association

	Type 2 National provider identifier	Tax identification number

Section 7: Provider secured services – Provider Enrollment and Change Self Service - continued

* The Authorized Web Access Administrator accepts responsibility and acknowledges that they have authority to act as the authorized representative (agent) of this group to enroll new practitioners via Provider Enrollment and Change Self Service.	☐ Yes ☐ No *Complete Addendum G
The authorized signer agrees that he/she has the company's designated authority to request and maintain minimum necessary Web access and is responsible for complying with all terms and conditions contained within the Provider Secured Service Use and Protection Agreement.	
*Authorized Signature	*Date

Section 8: Internet claims tool

If you currently submit paper claims and would like to submit electronic claims through this tool, complete Section 7 above, and the information below.

Check the payers and remittance report you would like to sign up for							
Blue Cross Blue Shield of Michigan	Blue Care Network	BCBSM Medicare Advantage	Medicare DME	Medicare	Medicaid	Commercial	Electronic Remittance
☐	☐	☐	☐	☐	☐	☐	☐
Internet browser and version							
Hardware and operating system							

Section 9: 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	*Practitioner signature/Title	*Date

When Completed