## 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:** 10584

**Type 2 NPI:**

**Tax Identification Number:**

| | Tax identification number | Type 2 National provider identifier |
|---|---|---|
| | | |

Use this form for:

## PART A - Group changes

- Change group name – Section 1
- Change group specialty – Section 2
- Change group EIN/TAX ID number and/or tax name – Section 3
- Request additional group networks – Section 4
- Terminate group networks – Section 5
- Change group participation status – Section 6
- Change group primary, remit and mailing address – Section 7
- Changing services – Section 8
- Adding a new group practice location – Section 9
- Closing a group practice location - Section 10

#

## PART B - Group member changes

- Add new group members – Section 11
- Assign members to group's primary and additional practice locations – Section 12
- Change group member's primary practice location – Section 13
- Change group members existing practice locations – Section 14
- End members relationship with group – Section 15

# Part A - Group changes

| Current group name | |
|---|---|

## Section 1: Change group name

| Current group name | |
|---|---|
| New group name | |

## Section 2: Change group specialty

| Current group specialty | |
|---|---|
| New group specialty | |

| | Tax identification Number | Type 2 National provider identifier |
|---|---|---|
| | | |

## Section 3: Change group EIN/Tax ID number and/or tax name

(Attach a document from the internal revenue service identifying the EIN or Tax ID and corresponding tax name)

| | |
|---|---|
| Current EIN/Tax ID | |
| New EIN/Tax ID | |

| | |
|---|---|
| Current EIN/Tax name | |
| New EIN/Tax name | |
| Effective date of change | |
| Tax exempt | ☐ Yes ☐ No |

## Section 4: Request additional group networks

**Requested effective date -** The actual effective date will be determined based on the provisions in the applicable Participation/Affiliation Agreement(s). Your requested effective date cannot precede the date the group was formed as a bona fide legal entity. **Important:** If applying to participate with Traditional, Vision, Hearing, BCN Commercial, BCN Advantage HMO SM, please return a completed Group Signature Document for each network and the Group Practice Agency Authorization and Acknowledgment Form located at http://www.bcbsm.com/provider/enrollment/

**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<br>(complete Group Signature Document and Group Agency Authorization and Acknowledgement form)<br>☐ Non-participating<br>Requested effective date: |
| Vision | ☐ Participating<br>(complete Group Signature Document and Group Agency Authorization and Acknowledgement form)<br>☐ Non-participating<br>Requested effective date: |
| Hearing | ☐ |
| **BCN networks** | **Requested networks** |
| BCN Commercial | ☐ |
| BCN Advantage HMO SM | ☐ |
| Blue Cross Complete | ☐ |

| | Tax identification number | Type 2 National provider identifier |
|---|---|---|
| | | |

## Section 5: Terminate group networks

**Requested termination date -** The actual date of your termination will be determined based on the provisions in the applicable participation agreements.

**Important: If you are terminating all networks, please complete the Group/Allied Provider Termination Form.**

**Select networks you are terminating:**

| **BCBSM networks** | **Requested termination date** |
|---|---|
| Traditional | ☐ Date: |
| Vision | ☐ Date: |
| Hearing | ☐ Date: |
| **BCN networks** | **Requested termination date** |
| BCN Commercial | ☐ Date: |
| BCN Advantage HMO SM | ☐ Date: |
| Blue Cross Complete | ☐ Date: |
| **Other** | **Requested termination date** |
| Medicare Plus Blue PFFS SM | ☐ Date: |

## Section 6: Change group participation status

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

**Select networks you are changing:**

| **BCBSM networks** | **Requested participation change** |
|---|---|
| Traditional | ☐ Nonparticipating to Participating<br>(complete Group Signature Document and Group Agency Authorization and Acknowledgement form)<br>☐ Participating to Nonparticipating<br>(effective 60 days upon receipt of request) |
| Vision | ☐ Nonparticipating to Participating<br>(complete Vision Group Signature Document and Vision Group Agency Authorization and Acknowledgement form)<br>☐ Participating to Nonparticipating<br>(effective 60 days upon receipt of request) |

| | Tax identification number | Type 2 National provider identifier |
|---|---|---|
| | | |

## Section 7: Change group primary, remit and mailing address

Check addresses that are changing: ☐ Primary ☐ Payment/Remit ☐ Mailing

**Note:** Enter only new address detail for those addresses that are changing.

| **Primary office address** (must be an address where health care services are rendered and may be published in BCBSM/BCN provider directories) | | | |
|---|---|---|---|
| Effective date: | | | |
| Street address | | | |
| City | State | ZIP code | County |
| **Address details** | | | |
| Primary telephone number must be a phone number patients can call to make an appointment. | | | |
| Telephone number | | Fax number | |
| Handicap accessibility ☐ Yes ☐ No Accessible by train ☐ Yes ☐ No<br>Accessible by bus ☐ Yes ☐ No | | | |

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

| **Payment/Remit address** | | |
|---|---|---|
| Effective date | | |
| Street address | | |
| City | State | ZIP code |

| **Mailing address** | | |
|---|---|---|
| Effective date | | |
| Street address | | |
| City | State | ZIP code |

Blue Cross Blue Shield Blue Care Network of Michigan

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

# Group Change Form

| | Tax identification number | Type 2 National provider identifier |
|---|---|---|
| | | |

## Section 8: Change services

**Services:** Change the services your group performs

| Radiology Services: | Add | Remove | |
|---|---|---|---|
| Bone Density | ☐ | ☐ | |
| CT Scan | ☐ | ☐ | |
| Radiation Oncology | ☐ | ☐ | |
| Mobile Unit | ☐ | ☐ | |
| MRI | ☐ | ☐ | |
| Fluoroscopy | ☐ | ☐ | |
| Nuclear Medicine | ☐ | ☐ | |
| MRI of Breast | ☐ | ☐ | |
| MRI - Open | ☐ | ☐ | |
| Routine Xray | ☐ | ☐ | |
| Ultrasound | ☐ | ☐ | |
| Mammography | ☐ | ☐ | |
| PET scan | ☐ | ☐ | |
| **Sleep Testing Services:** | Add | Remove | |
| Home Testing | ☐ | ☐ | |
| In-Center Sleep Testing | ☐ | ☐ | |

## Behavioral Health Services:

Note: The services below apply only to groups of psychiatrists, fully licesed psychologists and licensed master's social workers.

| Levels of Care/Services: | | | Age Categories: | | | |
|---|---|---|---|---|---|---|
| | Add | Remove | Child (0-12) | Adolesecent (13-17) | Adult (18-64) | Geriatric (65+) |
| Mental health outpatient services | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Substance abuse outpatient services | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Drug ambulatory outpatient detox | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Alcohol ambulatory outpatient detox | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

| | Type 1 National provider identifier | Type 2 National provider identifier |
|---|---|---|
| | | |

## Section 8: Change behavioral health services - continued

| **Psychiatric Specialty Services:** | |
|---|---|
| In-home mental health | Add ☐ Remove ☐ |
| Psychiatric RN | Add ☐ Remove ☐ |
| Social Work | Add ☐ Remove ☐ |

**Therapeutic modality:**
If adding: Please enter the percentage of cases treated in last 12 Months or list certification as indicated*

| Modality | Check ☑ | Modality | Check ☑ |
|---|---|---|---|
| Brief dynamic therapy | Add ☐ Remove ☐ % of Cases: | Interpersonal therapy | Add ☐ Remove ☐ % of Cases: |
| Eclectic therapy | Add ☐ Remove ☐ % of Cases: | Neuropsychological testing | Add ☐ Remove ☐ % of Cases: |
| Family therapy | Add ☐ Remove ☐ % of Cases: | Psychological testing | Add ☐ Remove ☐ % of Cases: |
| Group therapy | Add ☐ Remove ☐ % of Cases: | Applied behavior analysis for Autism spectrum disorders | Add ☐ Remove ☐ % of Cases: |
| Cognitive behavioral therapy* Add ☐ Remove ☐ Certification name: | | Dialectical behavioral therapy* Add ☐ Remove ☐ Certification name: | |

| | Type 1 National provider identifier | Type 2 National provider identifier |
|---|---|---|
| | | |

## Section 8: Change behavioral health services - continued

**Special areas of interest: To help us with patient referrals, please check off special areas of interest if you have particular expertise.**

| **Special areas of interest**<br>If adding: Please enter percentage of cases treated in last 12 Months | | | |
|---|---|---|---|
| Area of interest | Check ☑ | Area of interest | Check ☑ |
| Anger management | Add ☐ Remove ☐<br>% of Cases: | Anxiety/Panic disorders | Add ☐ Remove ☐<br>% of Cases: |
| Attention deficit hyperactivity disorders | Add ☐ Remove ☐<br>% of Cases: | Autism | Add ☐ Remove ☐<br>% of Cases: |
| Bariatric | Add ☐ Remove ☐<br>% of Cases: | Chronic medical illness | Add ☐ Remove ☐<br>% of Cases: |
| Dementia/Alzheimer's | Add ☐ Remove ☐<br>% of Cases: | Depression | Add ☐ Remove ☐<br>% of Cases: |
| Disability | Add ☐ Remove ☐<br>% of Cases: | Dissaociative disorders | Add ☐ Remove ☐<br>% of Cases: |
| Disorders of childhood & adolescence | Add ☐ Remove ☐<br>% of Cases: | Eating disorders | Add ☐ Remove ☐<br>% of Cases: |
| Gambling addiction | Add ☐ Remove ☐<br>% of Cases: | Gay/Lesbian | Add ☐ Remove ☐<br>% of Cases: |
| Gender identification/ transgender | Add ☐ Remove ☐<br>% of Cases: | Grief/Bereavement | Add ☐ Remove ☐<br>% of Cases: |
| HIV/AIDS | Add ☐ Remove ☐<br>% of Cases: | Obsessive compulsive disorders | Add ☐ Remove ☐<br>% of Cases: |

| | Type 1 National provider identifier | Type 2 National provider identifier |
|---|---|---|
| | | |

## Section 8: Change behavioral health services - continued

**Special areas of interest: To help us with patient referrals, please check off special areas of interest if you have particular expertise.**

| **Special areas of interest**<br>If adding: Please enter percentage of cases treated in last 12 Months | | | |
|---|---|---|---|
| Area of interest | Check ☑ | Area of interest | Check ☑ |
| Pain management | Add ☐ Remove ☐<br>% of Cases: | Personality disorders | Add ☐ Remove ☐<br>% of Cases: |
| Phobias | Add ☐ Remove ☐<br>% of Cases: | Post traumatic stress disorder | Add ☐ Remove ☐<br>% of Cases: |
| Schizophrenia/ Psychosis | Add ☐ Remove ☐<br>% of Case: | Sexual abuse | Add ☐ Remove ☐<br>% of Cases: |
| Sexual dysfunction | Add ☐ Remove ☐<br>% of Cases: | Traumatic brain injury | Add ☐ Remove ☐<br>% of Cases: |
| Women's Issues | Add ☐ Remove ☐<br>% of Cases: | | |

**All practitioner services:**

| | |
|---|---|
| Add ☐ Remove ☐<br>e-prescribing functionality Click here for explanation | Add ☐ Remove ☐<br>In-home visits |

# Group Change Form

| | Tax identification number | Type 2 National provider identifier |
|---|---|---|
| | | |

## Section 9: Adding a new group practice location

This information is required when adding a new practice location. Identify new address and all providers practicing at the new location. Must be an address where health care services are rendered and may be published in BCBSM and BCN provider directories.

| **New practice location** | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Effective date of new location:** | | | | | | | |
| Street address | | | | | | | |
| City | | | State | | | ZIP code | |
| Telephone number | | | Fax number | | | | |
| Handicap accessibility ☐ Yes ☐ No Accessible by train ☐ Yes ☐ No<br>Accessible by bus ☐ Yes ☐ No | | | | | | | |
| **Office hours** | Monday | Tuesday | Wednesday | Thursday | Friday | Saturday | Sunday |
| Open time | | | | | | | |
| Close time | | | | | | | |

**List all providers practicing at the new location.**

| First Name, Last Name, Degree | Type 1 NPI | If the new address is a Primary address for a provider, please check ☑ box |
|---|---|---|
| **1.** | | ☐ PRI |
| **2.** | | ☐ PRI |
| **3.** | | ☐ PRI |
| **4.** | | ☐ PRI |
| **5.** | | ☐ PRI |
| **6.** | | ☐ PRI |
| **7.** | | ☐ PRI |

If you have additional providers or addresses to add, please list and attach separately.

| | Tax identification number | Type 2 National provider identifier |
|---|---|---|
| | | |

## Section 10: Closing a group practice location

This information is required when closing a practice location. Identify address and all providers who were practicing at that location.

| **Close practice location** | | | |
|---|---|---|---|
| **Effective date:** | | | |
| Street address | | | |
| City | State | ZIP code | Telephone number |

**List all providers who were practicing at the above address. If this location is a primary address for this provider, you must indicate a new Primary Address in section 12**

| First Name, Last Name, Degree | Type 1 NPI |
|---|---|
| 1. | |
| 2. | |
| 3. | |
| 4. | |
| 5. | |
| 6. | |
| 7. | |
| 8. | |
| 9. | |
| 10. | |
| 11. | |
| 12. | |

If you have additional providers or addresses to close, please list and attach separately.

| | Tax identification number | Type 2 National provider identifier |
|---|---|---|
| | | |

# Part B - Group Member Changes

## Section 11: Add new group members

**Note:** If your group is participating with BCBSM and BCN, each new group member must return a signed Group Practice Agency Authorization and Acknowledgment Form located at http://www.bcbsm.com/provider/enrollment/ associated with their particular provider type, i.e., MD, DO, CNP, CNM, CRNA, etc.

**List group members to add:**

| *First name, Last name, Degree | *Type 1 NPI | *Effective date in group MM/DD/YY | *List practice address #'s from **Section 11 ,** where each provider practices (e.g., Primary, 1, 2 or All) |
|---|---|---|---|
| 1. | | | |
| 2. | | | |
| 3. | | | |
| 4. | | | |
| 5. | | | |
| 6. | | | |
| 7. | | | |
| 8. | | | |
| 9. | | | |
| 10. | | | |
| 11. | | | |
| 12. | | | |
| 13. | | | |
| 14. | | | |
| 15. | | | |
| 16. | | | |
| 17. | | | |
| 18. | | | |
| 19. | | | |
| 20. | | | |

| | Tax identification number | Type 2 National provider identifier |
|---|---|---|
| | | |

## Section 12: Assign members to group's primary and additional practice locations

This section must be completed if you are adding new members to your group.
Please list the primary practice location and all additional practice locations where new members of your group practice. This information is required for Section 10.

**Note: This section is not used for adding new group practice locations. Use Section 8.**

| **Primary** Street address | | |
|---|---|---|
| City | State | ZIP code |

| **#1 – Additional practice location** Street address | | |
|---|---|---|
| City | State | ZIP code |

| **#2 – Additional practice location** Street address | | |
|---|---|---|
| City | State | ZIP code |

| **#3 – Additional practice location** Street address | | |
|---|---|---|
| City | State | ZIP code |

**If you have additional practice locations, please list and attach separately.**

| | Tax identification number | Type 2 National provider identifier |
|---|---|---|
| | | |

## Section 13: Change group member's primary practice location

If you need to change a group member's primary practice location, please identify below.

| **#1 Member - Current primary practice location** | | | |
|---|---|---|---|
| Do you still practice at this location? ☐ No ☐ Yes<br>If No, effective date of change: | | | |
| First name | Last name | Degree | Type 1 NPI |
| Street address | | | |
| City | | State | ZIP code |
| Telephone number | | Fax number | |
| **New primary practice location** | | | |
| Street address | | | |
| City | State | ZIP code | County |
| Telephone number | | Fax number | |

| **#2 Member - Current primary practice location** | | | |
|---|---|---|---|
| Do you still practice at this location? ☐ No ☐ Yes<br>If No, effective date of change: | | | |
| First name | Last name | Degree | Type 1 NPI |
| Street address | | | |
| City | | State | ZIP code |
| Telephone number | | Fax number | |
| **New primary practice location** | | | |
| Street address | | | |
| City | State | ZIP code | County |
| Telephone number | | Fax number | |

| | Tax identification number | Type 2 National provider identifier |
|---|---|---|
| | | |

## Section 13: Change group member's primary practice location - continued

| **#3 Member - Current primary practice location** | | | |
|---|---|---|---|
| Do you still practice at this location? ☐ No ☐ Yes<br>If No, effective date of change: | | | |
| First name | Last name | Degree | Type 1 NPI |
| Street address | | | |
| City | State | ZIP code | |
| Telephone number | Fax number | | |
| **New primary practice location** | | | |
| Street address | | | |
| City | State | ZIP code | County |
| Telephone number | Fax number | | |

## Section 14: Change group members existing practice locations

Use this section to change additional practice address(es) for current group members.

| First name | Last name | Degree | Type 1 NPI |
|---|---|---|---|
| ☐ Add practice location ☐ End practice location Effective date: | | | |
| Street address | | | |
| City | State | ZIP code | |

| First name | Last name | Degree | Type 1 NPI |
|---|---|---|---|
| ☐ Add practice location ☐ End practice location Effective date: | | | |
| Street address | | | |
| City | State | ZIP code | |

| | Tax identification number | Type 2 National provider identifier |
|---|---|---|
| | | |

## Section 14: Change group members existing practice locations - continued

| First name | Last name | Degree | Type 1 NPI |
|---|---|---|---|
| ☐ Add practice location ☐ End practice location Effective date: | | | |
| Street address | | | |
| City | | State | ZIP code |

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

## Section 15: End members relationship with group

Note: Identify group member(s) who are no longer with your group.

| First name, Last name, Degree | Type 1 NPI | Effective date of termination MM/DD/YY | Check ☑ here if physician was acting as a BCN PCP |
|---|---|---|---|
| 1. | | | ☐ |
| 2. | | | ☐ |
| 3. | | | ☐ |
| 4. | | | ☐ |
| 5. | | | ☐ |
| 6. | | | ☐ |
| 7. | | | ☐ |
| 8. | | | ☐ |
| 9. | | | ☐ |
| 10. | | | ☐ |

If you have additional providers to terminate from your group, please list and attach separately.

# Group Change Form

| | Tax identification number | Type 2 National provider identifier |
|---|---|---|
| | | |

## Section 16: 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?<br>☐ E-mail ☐ U.S. Mail Click here for explanation |

## Section 17: Application signature

*denotes a required field

I certify that the information contained in this application is true and complete.

| *Print or type name of Group Representative | *Group Representative Signature | *Date |
|---|---|---|
| | | |

When Completed