Blue Cross
Blue Shield
Blue Care Network
of Michigan

GROUP/ALLIED PROVIDER TERMINATION FORM

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:

Dfcj]XYf˙9bfc``a Ybh
Blue Cross Blue Shield of Michigan
P.O. Box 217
Southfield, MI 48034

Form Number: 10586

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Type 2 NPI:

Tax Identification Number:

Blue Cross Blue Shield of Michigan and Blue Care Network are nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association

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

Group/Allied Provider Termination Form

	Tax identification number	Type 2 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 network(s) and/or group affiliation(s). 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:

Group/allied provider information:

Group name		
Primary Office Address		
Street address		
City	State	ZIP code
Primary telephone number	Fax number	
Specialty		

Contact information:

*denotes a required field

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

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Group/Allied Provider Termination Form

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

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

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.

*Print or type name Authorized Representative's Name	*Authorized Representative's Signature	*Date