Blue Cross Blue Shield Blue Care Network of Michigan

OSS/EFT New Provider Enrollment

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 in after each entry to move from field to field.
 - Providers and Facilities Please to be sure to include:
 - From (Insert name of contact person)
 - Date (MM/DD/YYYY)
 - National Provider Identifier (NPI)
 (Only submit one NPI per application. Multiple NPI's, submit multiple applications.)
 - Individual Provider (Type 1) or
 - Group (Type 2) or
 - Facilities (Type 2)
 - Tax identification number (must include a copy of your IRS tax identification document)
 - Medicare number

If you have questions on how to complete this form please contact provider enrollment at (800) 822-2761.

When you complete this form please fax it to: 866-900-0250



FAX COVER SHEET FOR DOCUMENTS

IMPORTANT: Attach this page to the top of your document to avoid processing delays.

	Fax To:	866-900-0250 PEDM
	From:	
	Date:	
(Only submit one NPI per applicatio	n. Multiple N	IPI's, submit multiple applications.)
Form Number:	14635	
Type 1 NPI:		
- 0.1101		
Type 2 NPI:		
Tax Identification Number:		

Blue Cross Blue Shield of Michigan is a nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association.



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

OOS/EFT NEW PROVIDER ENROLLMENT

Type 1 National Provider Identifier	Type 2 National Provider Identifier	Tax Identification Number

This enrollment form is only to be used for enrollment into the Electronic Funds Transfer (EFT) of Medicare cross over claim payments. Please indicate your provider type. If your provider type is not a selection, enter your information in the area identified as "Other". If you have questions regarding the completion and submission of this form please contact Provider Enrollment at 800-822-2761.

End-Stage Renal Disease Long-Term Acute Care Hospital Federally Qualified Health Center Outpatient Physical Therapy Facility Home Health Care Outpatient Psychiatric Care Facility Home Infusion Therapy Hospice Ancillary Providers: Ambulance Freestanding Radiology Center Optician/Optometric Supplier Long-Term Acute Care Hospital Substance Abuse Facility Outpatient Residential Other: Authorize Number Facility Fresting Facility Urgent Care Vision/Hearing Prosthetic Supplier	Section 1: Der	mographic Data			*denotes a required field		
*What type of proivder are you? Check all that apply. Facilities: Ambulatory Infusion Center Hospital Skilled Nursing Facility Ambulatory Surgery Facility Specialty: End-Stage Renal Disease Long-Term Acute Care Hospital Substance Abuse Facility Federally Qualified Health Center Outpatient Physical Therapy Facility Outpatient Residential Home Health Care Outpatient Psychiatric Care Facility Other: Home Infusion Therapy Psychiatric Residential Treatment Facility Hospice Rural Health Clinic Ancillary Providers: Ambulance Independent Diagnostic Testing Facility Urgent Care Freestanding Radiology Center Professional Group (Practitioners) Vision/Hearing Optician/Optometric Supplier	*Provider (d.b.a. nan	me) / Practitioner name					
Facilities: Ambulatory Infusion Center Ambulatory Surgery Facility End-Stage Renal Disease End-Stage Renal Disease Federally Qualified Health Center Home Health Care Home Infusion Therapy Hospice Ancillary Providers: Ambulance Freestanding Radiology Center Optician/Optometric Supplier Hospica Skilled Nursing Facility Swing Beds Yes Note Swing Beds Ye	*Medicare number						
Ambulatory Infusion Center Ambulatory Surgery Facility Specialty: End-Stage Renal Disease Long-Term Acute Care Hospital Substance Abuse Facility Federally Qualified Health Center Outpatient Physical Therapy Facility Outpatient Residential Home Health Care Outpatient Psychiatric Care Facility Home Infusion Therapy Psychiatric Residential Treatment Facility Hospice Rural Health Clinic Ancillary Providers: Ambulance Independent Diagnostic Testing Facility Urgent Care Freestanding Radiology Center Professional Group (Practitioners) Vision/Hearing Prosthetic Supplier	*What type of proive	der are you? Check all that app	 oly.				
Ambulatory Surgery Facility End-Stage Renal Disease Long-Term Acute Care Hospital Federally Qualified Health Center Home Health Care Home Infusion Therapy Hospice Ancillary Providers: Ambulance Freestanding Radiology Center Optician/Optometric Supplier Swing Beds Yes No Substance Abuse Facility Outpatient Physical Therapy Facility Outpatient Residential Fesidential Treatment Facility Urgent Care Vision/Hearing Prosthetic and Orthotic Supplier Prosthetic Supplier	Facilities:						
End-Stage Renal Disease Long-Term Acute Care Hospital Federally Qualified Health Center Outpatient Physical Therapy Facility Home Health Care Outpatient Psychiatric Care Facility Home Infusion Therapy Hospice Ancillary Providers: Ambulance Freestanding Radiology Center Optician/Optometric Supplier Long-Term Acute Care Hospital Substance Abuse Facility Outpatient Residential Other: Psychiatric Residential Treatment Facility Rural Health Clinic Urgent Care Vision/Hearing Prosthetic Supplier	Ambulatory	Infusion Center	Hospital		Skilled Nursing F	acility	
Federally Qualified Health Center Outpatient Physical Therapy Facility Outpatient Residential Home Health Care Outpatient Psychiatric Care Facility Other: Home Infusion Therapy Psychiatric Residential Treatment Facility Hospice Rural Health Clinic Ancillary Providers: Ambulance Independent Diagnostic Testing Facility Urgent Care Freestanding Radiology Center Professional Group (Practitioners) Vision/Hearing Optician/Optometric Supplier Prosthetic and Orthotic Supplier	Ambulatory	Surgery Facility	Specialty:		Swing Beds	Yes	No
Home Health Care Home Infusion Therapy Hospice Ancillary Providers: Ambulance Freestanding Radiology Center Optician/Optometric Supplier Outpatient Psychiatric Care Facility Psychiatric Residential Treatment Facility Rural Health Clinic Psychiatric Residential Treatment Facility Rural Health Clinic Urgent Care Vision/Hearing Prosthetic and Orthotic Supplier Prosthetic Supplier	End-Stage R	Renal Disease	Long-Term Acute	· Care Hospital	Substance Abuse	Facility	
Home Infusion Therapy Psychiatric Residential Treatment Facility Rural Health Clinic Ancillary Providers: Ambulance Independent Diagnostic Testing Facility Urgent Care Freestanding Radiology Center Optician/Optometric Supplier Prosthetic and Orthotic Supplier Prosthetic Supplier	Federally Qu	ualified Health Center	Outpatient Physic	cal Therapy Facility	Outpatient	Reside	ential
Hospice Rural Health Clinic Ancillary Providers: Ambulance Independent Diagnostic Testing Facility Urgent Care Freestanding Radiology Center Professional Group (Practitioners) Vision/Hearing Optician/Optometric Supplier Prosthetic and Orthotic Supplier Prosthetic Supplier	Home Healtl	h Care	Outpatient Psych	iatric Care Facility	Other:		
Ancillary Providers: Ambulance Independent Diagnostic Testing Facility Urgent Care Freestanding Radiology Center Professional Group (Practitioners) Vision/Hearing Optician/Optometric Supplier Prosthetic and Orthotic Supplier Prosthetic Supplier	Home Infusion	on Therapy	Psychiatric Reside	ential Treatment Facility			
Ambulance Independent Diagnostic Testing Facility Urgent Care Freestanding Radiology Center Professional Group (Practitioners) Vision/Hearing Optician/Optometric Supplier Prosthetic and Orthotic Supplier Prosthetic Supplier	Hospice		Rural Health Clini	ic			
Freestanding Radiology Center Professional Group (Practitioners) Vision/Hearing Optician/Optometric Supplier Prosthetic and Orthotic Supplier Prosthetic Supplier	Ancillary Provi	iders:					
Optician/Optometric Supplier Prosthetic and Orthotic Supplier Prosthetic Supplier	Ambulance		Independent Dia	gnostic Testing Facility	Urgent Care		
	Freestanding	g Radiology Center	Professional Grou	up (Practitioners)	Vision/Hearing		
Orthotic Supplier Other:	Optician/Op	otometric Supplier	Prosthetic and Or	rthotic Supplier	Prosthetic Suppli	er	
Orthodic Supplied	Orthotic Sup	pplier	Other:				
Professional Practitioners:	Professional P	ractitioners:					
MD DC DO DPM	MD	DC	DO	DPM			
PT DMD OT NP	PT	DMD	OT	NP			
Specialty:	Specialty:						
Other:	Other:						
*Date of birth:							
	l .						

Section 2: EIN / SSN Tax information

*denotes a required field

*EIN Tax ID number:	*SSN (Pra	ctitioner	only):	
*EIN / Tax name as indicated on Internal Revenue Service document				
*Tax exempt / Fiscal year end	Yes	No	F.Y.E. Date:	



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Type 1 National Provider Identifier	Type 2 National Provider Identifier		Tax Identification Number		
Section 3: Address Information				*denotes a required field	
Primary office address					
*Street address					
*City		*State		*ZIP code	
Primary telephone number	must be a phone nu	mber patients can	call to mak	te an appointment.	
*Primary Telephone number	·	Fax number			
Payment / Remit address					
Street address					
City		State		ZIP code	
Mailing address					
Street address					
City		State		ZIP code	
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			
Email					
Section 4: Application signature *denotes a required field					
I certify that the information contained	d in this application is	true and complete	э.		
*Authorized signature		*Signature / Title		*Date	