Blue Cross Blue Shield Blue Care Network of Michigan

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

AUTHORIZATION TO ADD/ REMOVE ACCESS FOR BCN, MAPPO, COMMERCIAL HEALTH e-BLUE FAX COVER PAGE

Fax To: _____

From (office): _____

Contact: _____

Date: _____

PLEASE NOTE!!

- We cannot accept handwritten forms.
- Do not hand write anywhere on the forms(except for the signature), otherwise processing will be delayed.
- To ensure forms are processed timely, please adhere to the following instructions:
  - Enter all information online(Google Chrome or Internet Explorer work best).
  - Press the tab key after each entry to move from field to field.

ATTENTION

We're always looking for ways to protect our member's information and keep your account secure. That's why we'd like to connect your online account to an email address that's related to your business rather than a public email provider such as Hotmail, Gmail or Yahoo.

If you have a company email address, please include it on your request for access or changes to your Provider Secured Services account at bcbsm.com. If you're not sure whether a company email address is available to you, check with your website administrator. Most websites offer a domain email free with your account. If you're a smaller practice that doesn't host a website, we'll accept your request with the email you use to conduct your business.

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AUTHORIZATION TO ADD/REMOVE ACCESS FOR BCN, MAPPO, COMMERCIAL HEALTH e-BLUE
(For existing Provider Secured Services users)

TYPE THE NAMES(S) AND THEIR CURRENT WEB-DENIS ID(S) BELOW

USER NAME	Provider Secured Service ID	USER NAME	Provider Secured Service ID

Adding Access (List the 10 Digit PCP License Numbers for BCN, MAPPO and/or Commercial)

_____ _____ _____

_____ _____ _____

Removing Access (List the 10 Digit PCP License Numbers for BCN, MAPPO and/or Commercial)

_____ _____ _____

_____ _____ _____

Adding PO Access (List the 12 Character PO IH Code and/or BCBSM Physician Name or Organization Identifier

_____ _____ _____

_____ _____ _____

Removing PO Access (List the 12 Character PO IH Code and/or BCBSM Physician Name or Organization Identifier

_____ _____ _____

_____ _____ _____

Authorization

By signing below, I represent I am a Provider or the Medical Care Group/Provider Group Representative and warrant that I have been granted full legal authority, by corporate resolution, appropriate delegated signature authority, or as permitted by a signature authorization policy, to enter into and bind the provider and/or provider group to contracts and agreements and intending to be legally bound have executed this agreement on the date below. Signing by a non-authorized person will cause the application to be returned for appropriate signature.

I understand that by signing this application I agree to only use and/or disclose BCN/BCBSM data for permissible treatment, payment and healthcare operations activities that allow me to service and care for my Blues patients. I also further agree that I will only use and/or disclose Medicare Advantage data to service and care for my Medicare Advantage patients.

_____ _____

Authorized Signer — Signer's Title

Do Not Use a Signature Stamp on the Authorized Signer Line above

_____ _____

Type or print name of signer above — Date

Fax #: 1 - 866 - 316 - 9243

Note. If additional space is needed, attach a separate listing of names and telephone numbers for each user requiring secured access.