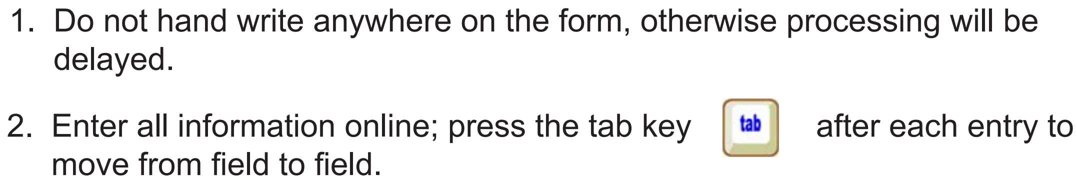
Blue Cross Blue Shield Blue Care Network of Michigan

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

OOS/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 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: 877-216-1682

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FAX COVER SHEET FOR DOCUMENTS

Fax To: **877-216-1682**

From:

Date:

(Only submit one NPI per application. Multiple NPI's, submit multiple applications.)

Form Number: 14635

Type 1 NPI:

Type 2 NPI:

Tax Identification Number:

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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.

Section 1: Demographic Data

*denotes a required field

*Provider (d.b.a. name) / Practitioner name

*Medicare number

*What type of provider are you?

Facilities:

- Ambulatory Infusion Center
- Ambulatory Surgery Facility
- End-Stage Renal Disease
- Federally Qualified Health Center
- Hospital
  - Specialty: ______________________
- Home Health Care
- Home Infusion Therapy
- Other: ______________________
- Hospice
- Long-Term Acute Care Hospital
- Outpatient Physical Therapy Facility
- Outpatient Psychiatric Care Facility
- Rural Health Clinic
- Psychiatric Residential Treatment Facility
- Skilled Nursing Facility
  - Swing Beds Yes No
- Substance Abuse Facility
  - Outpatient
  - Residential

  Check all that apply

Ancillary Providers:

- Ambulance
- Orthotic Supplier
- Prosthetic and Orthotic Supplier
- Freestanding Radiology Center
- Professional Group (Practitioners)
- Optician/Optometric Supplier
- Prosthetic Supplier
- Vision/Hearing
- Urgent Care
- Independent Diagnostic Testing Facility
- Other: ______________________

Professional Practitioners:

- MD
- PT
- DC
- DMD
- Other: ______________________
- DO
- OT
- DPM
- NP
- Specialty: ______________________

*Date of birth: ______________________

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Section 2: EIN/SSN Tax information

*denotes a required field

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

Section 3: Address Information

*denotes a required field

Primary office address		
*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		
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	

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Type 1 National provider identifier	Type 2 National provider identifier	Tax Identification number

Section 4: Provider secured services

*denotes a required field

Doing business electronically saves your office time and money. We encourage you to sign up for Provider Secured Services so that you can register for electronic funds transfer and have access to your vouchers online. Begin the process by completing the information in the section below:

Provider Secured Services Access Complete the section below for provider individuals that need access to Provider Secured Services for the NPI listed at the top of the page.	
*Name (full legal name of each user) *Telephone Number & E-mail	
*Name 1.	
*Telephone Number	E-mail
*Name 2.	
*Telephone Number	E-mail
*Name 3.	
*Telephone Number	E-mail
*Name 4.	
*Telephone Number	E-mail

Section 5: Application Signature

*denotes a required field

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

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.

(https://www.bcbsm.com/content/dam/public/Providers/Documents/help/faqs/use-and-protection-agreement-professional-facility.pdf)

*Authorized Signature	*Signature/Title	*Date