ECoS Forms — Instructions

Blue Cross Blue Shield **Blue Care Network**

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

New Subscriber Enrollment, Change of Status, or Primary Care Provider Selection

1 Select the appropriate forms

This packet includes three forms. See below to determine which form you should use.

New Subscriber Enrollment (page 3):

Use this form to enroll a subscriber in a new plan:

- During open enrollment
- As a new hire
- When returning from layoff or rehired
- Because subscriber has **lost eligibility** on another plan (loss of coverage). If coverage is lost from an insurance carrier other than Blue Cross or BCN, a letter of credible coverage is required.
- As a retiree
- When **surviving spouse** is eligible for enrollment as a new subscriber
- When a spouse or dependent is enrolling in **COBRA** as a new subscriber

Change of Status (page 5):

Use this form to make changes to an existing plan, such as:

- Adding a dependent, including a spouse or child
- Removing a dependent, including a spouse or child
- Transferring subscriber to a new division/ subgroup
- Changing or correcting personal information, such as name, address, email or phone number.
- Transferring an existing subscriber to a COBRA plan

Primary Care Provider Selection (page 4) Complete this form if:

- Subscriber is enrolling in a BCN HMO plan or the Physicians Choice PPO plan
- Subscriber, spouse or dependent is changing PCP - this can also be done conveniently online or in the Blue Cross app

2 Note the codes and documentation you will need

Use the codes below to complete sections B and D of the New Subscriber Enrollment or Change of Status forms.

Section B. Dependent information

Use codes below to indicate relationship.

Spouse SP

Domestic Partner* **DP**

Child (by birth or adoption) N

Stepchild S

Child adoption in process** A

Legal Guardianship** L

Disabled child*** D

Sponsored dependent* SD

Foster child FC

Court Order Coverage (QMCSO)** C

*Attach documentation

**Attach court order

***Attach provider statement

Section C. Other health care coverage

Members with other health care coverage can contact insurer to find the original effective date.

If any members are enrolled in Medicare, please attach a copy of the Medicare card.

Section D. Health savings, health reimbursement and flexible spending account options

Do not complete for Blue Care Network members. If the plan offers HSA, HRA or FSA accounts and you are enrolling in one, use the codes below to indicate the account type you have selected.

HSA only **1000**

HSA with limited purpose FSA 1070

HSA with dependent care FSA 1004

HSA with limited purpose FSA & dependent care FSA 1074

HSA with limited purpose HRA 1600

HSA Opt Out - High deductible plan without HSA 0000

HRA only **0100**

HRA with limited purpose FSA 0170

HRA with dependent care FSA 0104

HRA with limited purpose FSA & dependent care FSA 0174

HRA with health care FSA 0110

HRA with health care FSA & dependent care FSA 0114

Health care FSA 0010

Dependent care FSA 0004

Health care and dependent care FSA 0014

PPO without Health care FSA 0000

Section E. Employer/Group use only

New subscriber enrollment/COBRA: For a spouse or dependent applying to be the subscriber on a COBRA plan, the duration is always 36 months. Change of status/COBRA: For an existing subscriber changing to a COBRA plan, where the qualifying event is termination, COBRA duration is 18 months. In certain circumstances, if a disabled subscriber and non-disabled family members are qualified beneficiaries, they are eligible for up to an 11-month extension of COBRA coverage, for a total of 29 months.

3 Complete the forms and send to Membership and Billing — Be sure that:

- Employer representative has signed New Enrollment or Change of Status form.
- Subscriber has read the contract conditions on page 2 and signed where indicated on each form.
- All required documentation is attached.

For Blue Cross Blue Shield of Michigan Mail:

Blue Cross Blue Shield of Michigan Membership and Billing - M.C. 610I P.O. Box 2260

Detroit, MI 48226 Fax: 1-866-900-2619

Email:

GroupCustomerMembership@BCBSM.com BCNGroupMembership@BCBSM.com

For Blue Care Network

Mail:

Blue Care Network

Membership and Billing - M.C. C300

P.O. Box 5043

Southfield, MI 48086 Fax: 1-877-218-1466

Email:

Blue Cross Blue Shield Blue Care Network of Michigan

Subscriber Agreement

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

Please read the following information before completing the attached forms. The information on these forms and the following conditions are part of your contract with Blue Cross Blue Shield of Michigan or Blue Care Network of Michigan.

I am applying for health care coverage with Blue Cross Blue Shield of Michigan or Blue Care Network, or I am modifying existing coverage for myself or enrolled family members. Coverage begins on the date determined by Blue Cross or BCN. When Blue Cross or BCN accepts my application or changes, my enrolled family members and I are bound by the terms of the Blue Cross or BCN certificates, riders, other coverage documents, policies and these forms. I understand that submitting false or misleading information or omitting material information on these forms may result in rejection of my changes or retroactive termination of my coverage.

Proof of eligibility: I agree to provide proof of my enrolled family members' eligibility for coverage when requested by Blue Cross or BCN.

Authorization: I appoint my employer or association to handle all matters of coverage. My employer may forward any agreed deductions for coverage from my wages. I am responsible for notifying my employer or association of changes in my status or my family's status that affect coverage, such as marriage, divorce, birth, Medicare entitlements or death of someone enrolled on the plan. I authorize Blue Cross or BCN or my primary care provider to obtain the medical records relating to me and my enrolled family members needed to coordinate our medical care, administer my Blue Cross or BCN coverage and for other purposes necessary for Blue Cross or BCN to fulfill its contractual and statutory obligations.

Health Insurance Portability and Accountability Act: If I lose my eligibility for coverage, I may be entitled to special enrollment rights under HIPAA. Blue Cross or BCN reserves the right to request written verification of the date of the event and reason for loss of eligibility from my previous group or carrier. HIPAA special enrollment rights do not preempt a new hire waiting period, which must first be satisfied. Termination of employment may qualify for special enrollment rights, but voluntary terminations of other health care coverage do not.

Release of health care information: I acknowledge that Blue Cross or BCN requires me to provide my Social Security number. In applying for coverage, My enrolled family members and I agree to permit health care providers and others to release "protected health information (as defined

in the Health Insurance Portability and Accountability Act of 1996) to Blue Cross or BCN for administering our coverage. Upon my request, Blue Cross or BCN will tell me where the information was sent. If I have enrolled in a flexible spending account or health reimbursement arrangement through my employer, I authorize Blue Cross or BCN to provide claim information pertaining to me and my enrolled family members to the account administrator to facilitate reimbursement.

Group representative information: The group confirms that the status change requested complies with and is permitted under applicable state and federal law, including the Patient Protection and Affordable Care Act.

Blue Care Network only

My enrolled family members and I agree that all our medical services may be performed, prescribed, directed or authorized by our designated BCN primary care provider except in the case of an immediate and unforeseen medical emergency when the time needed to contact our primary care provider may mean permanent damage to our health. Unauthorized services that aren't an emergency as described above, received from non-BCN providers, won't be covered.

I agree to assign to BCN the right to recover from any person or organization the cost of hospital, medical and prescription services delivered by or paid for by BCN as a result of accident or disease, including injuries or disease claimed under workers' compensation laws or acts, whether by redemption award, voluntary payment or otherwise.

I authorize any holder of medical or other information about me or my enrolled family members to release any information needed to determine benefits coverage to the Centers for Medicare and Medicaid Services, any insurance company or any HMO and their agents. I request that payment of authorized Medicare, Medicaid, insurance company or HMO benefits be made payable to BCN on my behalf for any services that BCN provides to me and my enrolled family members.

New Subscriber Enrollment

For BCN, or Physician Choice PPO, also complete page 4, Primary Care Provider Selection form

Blue Cross Blue Shield of	Michigan	☐ Blue Care Network							
Blue Cross group number	Division	BCN group number	Subgroup number Class number						



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Provider Se	Tovider Selection form Employer representative signature SIGN of the Blue Cross and Blue Shield Association																	
A. Subscriber information																		
☐ Non-U.	S. citizen	Soci	ial Security /TI	N number (requir	red)	Subscriber legal last	Subscriber le	Subscriber legal first name M.I.					Gender/Sex					
Subscribe	criber birth date Home street address				City							State						
Country - if other than USA			Primary telephone number Ho			ork	Second	dary telep	phone number	one number		nail		,				
B. Depe	B. Dependent information — List all family members to be covered. If you have more than four dependents, complete additional copies of this form.																	
Legal last name				Legal first name			M.I.		er/Sex	Birth date	th date Non-U.S. Social citizen number					Relationship (see instructions for codes)		
Spouse										M								
Dep. 1										Μ								
Dep. 2									□F	М								
Dep. 3									□F	M								
Dep. 4									□F	\square M								
			· ·	· · · · · · · · · · · · · · · · · · ·	different fron	n the subscriber addre	ess abov	e, plea	ase cor		e information be	elow:						
Spouse or dependent (full name) Street address							City					State				ZIP code		
C. Other	health	care	coverage (Coordination	of benefit	s and Medicare i	nforma	tion)			·							
have othe	r health c		dependents overage?	Person covered	(full name)		ı				Check	if this applie	s to all ı	members	on this co	ontract		
Yes If yes, con	_	section	on.	Employer or gro	oup name Policy no				ər		Insurer	Insurer			Original effective date			
Are any m	embers l	isted	enrolled in Me	edicare? 🗌 Yes	s 🗌 No	If yes, check category	/: 🗌 Ov	er 65	and wo	rking	Retiree D	isabled	SRD	Medic	are ID			_
☐ Medica	. ,			bscriber Spc	iouse						Medicare A effe	ctive date	Medica	re B effec	effective date Medicare D effe			е
I have rea	d and und	dersta	and the condi	tions of this forr	n Subsci	riber signature SIGN										Dat	e	
D. Healt	h saving	ıs, he	ealth reimb	ursement and	l flexible s	pending account	t option	ıs - B	lue C	ross co	overage only.	See page	1 inst	ructions	for proc	luct code	S.	
Select acc	ount optic	on:]HRA □I		FSA goal a				Opt o		ue Cross produc				•			
E. Emple	oyer/Gro	oup u	use only															
Group nan	ne			Employer refere	ence ID D	epartment ID		Ben	efit cod	le	Plan code	•		Hire date	•	Effe	ective date	
Check cov		Check enrollment type: ☐ Open enrollment ☐ New hire ☐ Rehire ☐ Return from layoff ☐								Surviving sp	ouse 🔲		Salary D Hourl	ly				
Medica	ı [ss of eligibility	Insurer's name	e (including Blue Cross & BCN)							Policy number						
Vision		(prid	or coverage)	Contract holde	r						Termin	ation date _				□	Part time	
Dental Pharma	acy [JII	Previous contract number Original qualif					qualifying date	

Primary Care Provider Selection

Use this form to choose or change primary care providers for your BCBSM Physician Choice PPO or BCN HMO.



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Choose a primary care provider at enrollment

If you are enrolling in Blue Cross Blue Shield of Michigan Physician Choice PPO or Blue Care Network, you must select a primary care provider for yourself and each person on your contract. If you have more than four dependents, use additional copies of this form.

- You can choose a single PCP for your entire family, or different PCPs for different family members.
- Only family or general practice providers can serve as a PCP for the entire family.
- You cannot choose a specialist as your PCP.
- Subscribers must provide their Social Security number, if they are U.S. citizens, or tax identification number (TIN) if they are non-U.S. citizens.

Subscriber Social Security/TIN number (required)

Change your primary care provider

You may also change your primary care provider by logging onto your bcbsm.com account or using the bcbsm.com mobile app.

- If using this form, all changes become effective two business days after we receive this form, unless you request a later effective date. You cannot select an earlier date.
- If you change your primary care provider while being treated by a specialist, your new primary care provider must reauthorize the treatment you're receiving. Your treatment may not be covered until that occurs. You may ask to change your primary care provider effective immediately by calling the Customer Service number on the back of your Blue Cross or BCN ID card.

BCN subgroup/Blue Cross division number | BCN class number

citizen	5. , · · · · · · · · · · · · · · · ·	2010 2010 2010 2010 2010 2010 2010 2010											
Citizeri	I						l						
Member Information													
	Member last name, first name	Provider last name	e, first name	Provider's NPI# Can be found on bcbsm.com/find-a-doc	Provide	er address	If changing reason	g PCPs, list	Seen in the last 12 months?				
Subscriber									☐ Yes ☐ No				
Spouse									☐ Yes ☐ No				
Dep. 1									Yes No				
Dep. 2									☐ Yes ☐ No				
Dep. 3									Yes No				
Dep. 4									☐ Yes ☐ No				
Group/Employer name Effective date of cha													
I have read	Signature date												

RCN/Rlue Cross group number

Need information about available primary care providers?

Our website, bcbsm.com/find-a-doctor, provides the most current information on Blue Cross and BCN-affiliated primary care providers, including the NPI# required above. You can search for a family practice, general medicine, internal medicine, pediatrics, preventive medicine, city or hospital group.

For Blue Cross Blue Shield of Michigan:

Mail completed form to:

Blue Cross Blue Shield of Michigan Membership and Billing – M.C. 610l P.O. Box 2260 Detroit, MI 48226

Fax to 1-866-900-2619

For Blue Care Network:

Mail completed form to:

Blue Care Network Membership and Billing – M.C. C300 P.O. Box 5043 Southfield, MI 48086-5043

Fax to 1-877-218-1466

Change of Status

Use this form to change personal information, add or delete a member, transfer division or transfer an existing subscriber to COBRA.

☐ Blue Cross Blue Shield	of Michigan	☐ Blue Care Network								
Blue Cross group number	Division	BCN group number	Subgroup number	Class Number						
Employer representative signs	sture SIGN		Date							



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subscriber to CC	JBRA.		Employe	errepresent	alive s	signature D	IGIN														
A. Subscribe	er info	rmation –	Fill in the fie	elds marke	ed wi	th an aste	risk only i	if the inform	ation	has c	nangeo	d									
☐ Non-U.S. cit	izen	Social Securit	y /TIN number	(required)	Sı	ubscriber leç	gal last nam	ne				Subscriber le	oscriber legal first name				Marita	status*	Gender/Sex*		
Subscriber birth	n date	New home	street address	*					City*					State			e*	ZIP co			
County*	* Country* - if other than USA Primary telephone #* Home Work Ce					ork Cell	Secor	ndary te	elephone	e #* Home	Work	Cell	Cell Email*								
B. Depender	nt info	rmation –	List all fami	ily membe	ers to	be covere	ed. If you l	have more	than f	our de	epende	ents, comple	ete additi	onal c	opies of	f this f	orm.				
				Legal first name			M.I.	Gend	er/Sex	Birth Date	h Date Non-U.S. Social					Relationship (see instructions for codes)					
Spouse										□F	М			l							
Dep. 1 ☐ Add ☐ Delete										□F	М			ı							
Dep. 2 ☐ Add ☐ Delete										□F	М										
Dep. 3 ☐ Add ☐ Delete										□F	М										
Dep. 4 ☐ Add ☐ Delete										□F	М			l							
If the permanen					ent S	Spouse or d	lependent (1	full name)	Home address				City	City		Sta	ate	ZIP code			
C. Other hea	alth ca	are coveraç	ge (Coordina	ation of b	enef	its and M	edicare ii	nformation	1)			,							'		
Do you, your s				overed (full n	name)				Check if this applies to all members on this contract												
Yes No	e this se	ection.	Employer	or group na	ame	Policy number						Insurer Original effective date									
Are any memb	ers list	ed enrolled i	n Medicare?	Yes	No	If yes, ched	ck category	/: ☐ Over 65	and v	and working Retiree Disabled ESRD Medicare						are ID					
☐ Medicare pri☐ Blue Cross o	,		Subscriber Dependent:							Medicare A effective date					Medicare B effective date M				ledicare D effective date		
I have read and					Subso	criber signat	ture SIGN						Date								
D. Health sa	vings	, health rei	mbursemen	nt and flex	kible	spending	account	options -	Blue	Cross	cover	age only. S	ee instru	ctions	for pro	duct s	electio	n code	5		
□HRA □H	HSA	☐FSA FS	SA goal amoun	nt			Opt out	В	lue Cr	Cross product indicator code: Add/Change Cancel									ancel		
E. Employer	/Grou	p use only																			
Group name Employer Reference ID										Departm	Department ID Benefit code Plan code						;				
Type of change	e: 🗌 N	lame Ad	dress Add	d member	Ве	enefit chang	e			Ev	ent date	e Cancella	ation: chec	ck type	☐ Conf	ract [Spou	se 🔲 [Dependent		
☐ Transfer: nev	w divisi	on/subgroup		□	Subsc	criber COBF	RA enrollme	ent: 🗌 18 📗	29 mo:			Check reason: ☐ Left employment ☐ Retired ☐ Death ☐ Divorce									
Loss of eligibil				-			Policy numb	oer			fective ate		mploymer insurance	_	_			☐ Divor			
Insurer (including Blue Cross & BCN) Policy number Contract holder Termination date												Last date	e of covera	age							

We speak your language

If you, or someone you're helping, needs assistance, you have the right to get help and information in your language at no cost. To talk to an interpreter, call the Customer Service number on the back of your card.

Si usted, o alguien a quien usted está ayudando, necesita asistencia, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al número telefónico de Servicio al cliente, que aparece en la parte trasera de su tarjeta.

إذا كنت أنت أو شخص آخر تساعده بحاجة لمساعدة، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك دون أية تكلفة. للتحدث إلى مترجم اتصل برقم خدمة العملاء الموجود على ظهر بطاقتك.

如果您,或是您正在協助的對象,需要協助,您 有權利免費以您的母語得到幫助和訊息。要洽詢 一位翻譯員,請撥在您的卡背面的客戶服務電話

کی بخسلان کی بند فئی فیم دومته به با به بندید کی بختی به بازی که بازی کا به بند فئی به بازی کا به بازی کا به به بازی کا بازی کا به بازی کا بازی کا به بازی کا بازی کاری کا بازی کا باز

Nếu quý vị, hay người mà quý vị đang giúp đỡ, cần trợ giúp, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi số Dịch vụ Khách hàng ở mặt sau thẻ của quý vị.

Nëse ju, ose dikush që po ndihmoni, ka nevojë për asistencë, keni të drejtë të merrni ndihmë dhe informacion falas në gjuhën tuaj. Për të folur me një përkthyes, telefononi numrin e Shërbimit të Klientit në anën e pasme të kartës tuaj.

만약 귀하 또는 귀하가 돕고 있는 사람이 지원이 필요하다면, 귀하는 도움과 정보를 귀하의 언어로 비용 부담 없이 얻을 수 있는 권리가 있습니다. 통역사와 대화하려면 귀하의 카드 뒷면에 있는 고객 서비스 번호로 전화하십시오. যদি আপনার, বা আপনি সাহায্য করছেন এমন কারো, সাহায্য প্রয়োজন হয়, তাহলে আপনার ভাষায় বিনামূল্যে সাহায্য ও তথ্য পাওয়ার অধিকার আপনার রয়েছে। কোনো একজন দোভাষীর সাথে কথা বলতে, আপনার কার্ডের পেছনে দেওয়া গ্রাহক সহায্তা নম্বরে কল করুন।

Jeśli Ty lub osoba, której pomagasz, potrzebujecie pomocy, masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer działu obsługi klienta, wskazanym na odwrocie Twojej karty.

Falls Sie oder jemand, dem Sie helfen, Unterstützung benötigt, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer des Kundendienstes auf der Rückseite Ihrer Karte an.

Se tu o qualcuno che stai aiutando avete bisogno di assistenza, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, rivolgiti al Servizio Assistenza al numero indicato sul retro della tua scheda.

ご本人様、またはお客様の身の回りの方で支援を必要とされる方でご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合はお持ちのカードの裏面に記載されたカスタマーサービスの電話番号までお電話ください。

Если вам или лицу, которому вы помогаете, нужна помощь, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону отдела обслуживания клиентов, указанному на обратной стороне вашей карты.

Ukoliko Vama ili nekome kome Vi pomažete treba pomoć, imate pravo da besplatno dobijete pomoć i informacije na Vašem jeziku. Da biste razgovarali sa prevodiocem, pozovite broj korisničke službe sa zadnje strane kartice.

Kung ikaw, o ang iyong tinutulungan, ay nangangailangan ng tulong, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa numero ng Customer Service sa likod ng iyong tarheta.

Important disclosure

Blue Cross Blue Shield of Michigan and Blue Care Network comply with Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. Blue Cross Blue Shield of Michigan and Blue Care Network provide free auxiliary aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and information in other formats. If you need these services, call the Customer Service number on the back of your card. If you believe that Blue Cross Blue Shield of Michigan or Blue Care Network has failed to provide services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance in person, by mail, fax, or email with: Office of Civil Rights Coordinator, 600 E. Lafayette Blvd., MC 1302, Detroit, MI 48226, phone: 888-605-6461, TTY: 711,

fax: 866-559-0578, email: <u>CivilRights@bcbsm.com</u>. If you need help filing a grievance, the Office of Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health & Human Services Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by

mail, phone, or email at: U.S. Department of Health & Human Services, 200 Independence Ave, S.W., Washington, D.C. 20201, phone: 800-368-1019, TTD: 800-537-7697,

email: oCRCcomplaint@hhs.gov. Complaint forms are available at

http://www.hhs.gov/ocr/office/file/index.html.