Blue Cross Blue Shield Blue Care Network of Michigan

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

Addendum "B"
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.

Blue Cross Blue Shield Blue Care Network of Michigan

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

ADDENDUM "B" Authorization

Authorization for Representative Access to Provider Secured Services/e-referral Form

Please complete electronically

Section 1.

Billing Service/Service Bureau, TPA Name (where users are located)			
Street Address and Suite Number (address where users are located)			Billing Service/Service Bureau, TPA Contact Person
City	State	Zip Code	Contact Person's Telephone Extension
Billing Service/Service Bureau, TPA Tax ID			Contact Person's company issued email address

Section 2.

ADD NPI(s)

If NPI(s) should be added, list NPI(s) and User ID(s) below.

Add to the below User IDs:
ID is either a P####### or F#######

Provider or Group Name	NPI Number	Tax ID	User ID
	10-digit NPI Number	Tax ID	User ID
	10-digit NPI Number	Tax ID	User ID
	10-digit NPI Number	Tax ID	User ID
	10-digit NPI Number	Tax ID	User ID

☐ Check to also receive e-referral access _____ Set ID

Section 3.

REMOVE NPI(s)

If NPI(s) should be removed, list NPI(s) and User ID(s) below.

Remove from the below User IDs:
ID is either a P####### or F#######

☐ Remove NPI from all IDs

Provider or Group Name	NPI Number	User ID	User ID
	10-digit NPI Number		
	10-digit NPI Number		
	10-digit NPI Number		

Section 4.

Authorization for Provider Secured Services and/or e-referral (To be completed by the Provider or the Authorized Representative for the provider/ facility).

This Authorization for Representative Access Form permits you to authorize a billing service or TPA to have access to designated information for your individual and/or group provider NPI(s) for both Provider Secured Services and/or e-referral access.

The Billing Service, Service Bureau or TPA listed above, is authorized to access the information provided via Provider Secured Services and/or e-referral either now or in the future, for both individual and/or group NPI(s) which is the minimum information necessary for performing their job function. If the Authorized Representative's duties involve the use or disclosure of Protected Health Information (PHI), then the Health Insurance Portability and Accountability Act of 1996, as amended (HIPAA), and stricter state and federal laws, as applicable, require the PHI be protected from inappropriate uses or disclosures.

By signing below, I represent I am a Provider or the Authorized Representative for the Provider/facility and warrant I have been granted full legal authority by corporate resolution to update BCBSM enrolled NPI(s) to Provider Secured Services login ID's and/or e-referral on the date set forth below. If the signatory contractually represents multiple providers in the business of health insurance billing/inquiry, they must include a printout of all such codes with this Addendum.

In addition, I understand that by signing below I have the company's designated authority to request and maintain minimum necessary web access and am responsible for complying with all terms and conditions contained within the Billing Service/Third Party Management Use and Protection Agreement.

https://www.bcbsm.com/content/dam/public/Providers/Documents/help/billing-service-use-and-protection-agreement.pdf

Signature of Provider/Facility Authorized Individual
Handwritten Signature Only

Title of Authorized Individual

Type Name of the Authorized Signer

Date

For questions call 1-877-258-3932

Send Fax to 1-800-495-0812

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