



Provider Secured Services ID Reassignment

Please complete electronically

Practice or Facility Name:			Contact Person:		
Street Address and Suite Number:			Contact Person's Telephone and Extension:		
City:	State:	ZIP Code:	Work Email Address:		

This form allows you to reassign an existing Provider Secured Services ID that is no longer being used by your practice to another user in your practice. List below each Provider Secured Services ID you would like to reassign, the previous user, the new user, and the new user's telephone number.

The access assigned to the current Provider Secured Services ID will be transferred to the new user. This includes, but is not limited to: Eligibility, Claims Tracking, Electronic Funds Transfer (EFT), Internet Claims Transmission (ICT), and Provider Enrollment Change Self-Service. The new user will be bound to the original terms and conditions of all access that has been acquired.

Note: Reassigned users with access to Provider Enrollment and Change Self Service understand, acknowledge, and attest to the original terms of the Addendum G, including the authority to maintain practitioner and provider group enrollment records for all Blue Cross Blue Shield of Michigan provider codes currently associated with the user as well as any future provider codes assigned.

Provider Secured Services ID	Previous User	New User	Telephone Number	Reassign	Reconnect	Disconnect
Example P000000	John B Doe	Jane Smith	248-222-1112 Ext. 231	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

If additional space is required, attach a separate listing that includes the Provider Secured Services ID, previous user, new user, and the user's telephone number.

By signing below, I represent and warrant that I am an authorized group representative; I have been granted, by corporate resolution or otherwise, full legal authority to enter into and bind my provider group to agreements. I understand, acknowledge, and attest that the user(s) listed above have the authority to perform all transactions associated with the requested features on behalf of the Provider Group, Individual Provider, and/or Provider Organization, and that I (as the Provider Group, Individual Provider, and/or Provider Organization) am responsible for all actions undertaken by the listed individuals.

AUTHORIZATION FOR USE AND ACCESS

<p style="text-align: center;">_____</p> <p style="text-align: center;">Authorized Signature Do not use a signature stamp on the line above</p>	<p style="text-align: center;">_____</p> <p style="text-align: center;">Date</p>
<p style="text-align: center;">_____</p> <p style="text-align: center;">Type Name of the Authorized Individual</p>	<p style="text-align: center;">_____</p> <p style="text-align: center;">Title of Authorized Individual</p>

For Questions Call 877-258-3932

Send Fax to 800-495-0812

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