



e-referral Request for Group ID Changes

Date: _____

* required fields

Authorization for representative access to e-referrals (I-Exchange)

I hereby authorize access to any and all information provided via e-referrals (I-Exchange), either now or in the future, for both my individual and/or group provider code(s).

*Please **add** **delete** (select one) the following users to my existing e-referral

*I-Exchange ID#: _____ *Practice name: _____

User name (print first and last name)	Current user web-DENIS ID
_____	_____
_____	_____
_____	_____

*Please **add** **delete** (select one) the following providers to my existing e-referral

*I-Exchange ID#: _____

Provider name (print first and last name)	*10-digit NPI
_____	_____
_____	_____
_____	_____

I hereby state that the information on this request is correct and the provider codes listed pertain to my practice/facility.

_____	_____	
*Provider/facility representative name	Date	
_____	_____	
Title of representative above	*Tax ID number	
_____	_____	
*Telephone number	Fax number	E-mail address
_____	_____	_____

Note: If the name above contractually represents multiple providers/codes in the business of health insurance billing/inquiry, they must include a print out of all such codes with this agreement.

Use the submit button to send the completed form electronically to the BCN Provider Affairs office. The submit feature requires an installed e-mail application. Alternately, you may save the completed form locally and e-mail it as an attachment to EastRPA@bcbsm.com or fax the completed form to 810-720-8627.

[Contact BCN Provider Affairs if you have questions.](#)

This box for BCN use only.

The data on this form will be loaded by BCBSM as represented. MCO representative signing below verifies accuracy of data.

BCN provider representative