



**Blue Care
Network
of Michigan**

e-referral Application

* required fields

*Provider/facility name: _____ *Specialty/department: _____

*Address: _____ *Contact: _____

_____ *Telephone: _____

*City, state, zip: _____ Fax: _____

_____ E-mail: _____

Physician offices: Please list the first and last names, and NPI codes for the physicians requesting e-referral access. Facilities: Please list the facility name and NPI codes for the facility requesting e-referral access:

Provider (first and last name)/facility name	*10-digit NPI

Please list the names and the codes for the user requesting e-referral access:

*User name (first and last name)	Current web-DENIS ID

e-referral Application

Authorization for use and access

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

*Provider/Facility representative name

Date

Title of representative above

*Tax ID number

If you have any questions, please call the bcbsm web-DENIS coordinator at 877-258-3932.

All confidentiality provisions of the BCBSM/BCN Participating Hospital Agreement are applicable to every individual user being granted access to member contract, referral and claim information via e-referral.

On behalf of the requesting entity the signer agrees:

1. To identify each individual employee authorized for access to e-referral. (User ID's may not be shared)
2. To use the data obtained only in the manner specified by Blue Cross Blue Shield of Michigan (BCBSM) applicable agreements.
3. To certify that any data obtained or submitted shall be for services performed by or under direct supervision of the facility name above.
4. To assure that the information obtained or transmitted shall be confidential and used only for the purpose of transacting BCBSM business.

NOTE: If multiple IDs are being requested, please attach a separate listing of the names and telephone numbers for each user requiring access to e-referral. All confidentiality provisions of the BCBSM Participating Hospital Agreement are applicable to every individual user being granted access to member contract and claim information via e-referral.

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.

Region: E M SE W

Type: PCP Spec. PCG Fac/Anc

BCN provider representative