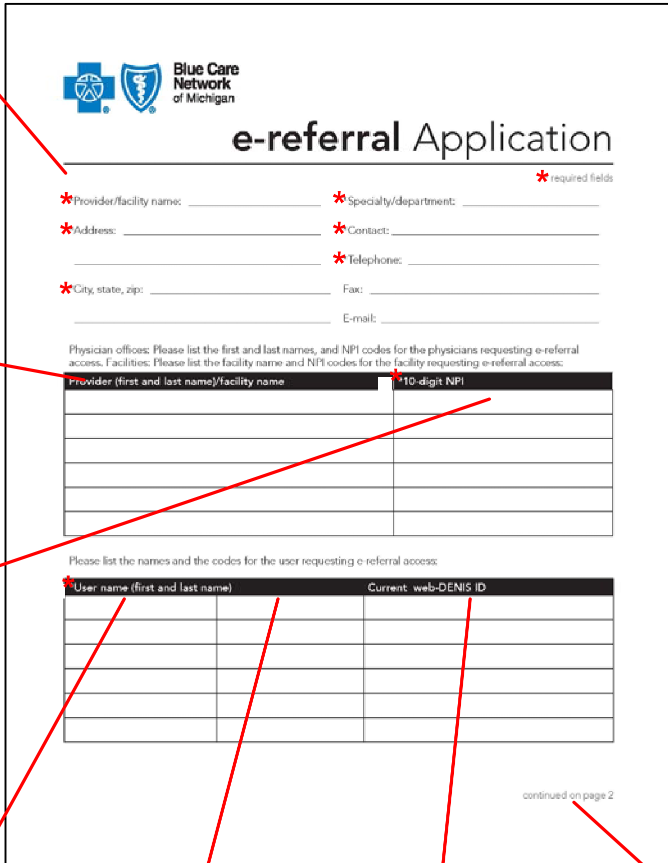
How to complete and submit the e-referral Application form

Complete all fields marked by an asterisk (*)

Type provider's first and last name or facility name here

In this section, list the names of each provider

Type provider or facility NPI here



e-referral Application

* required fields

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

*Address: ____________ *Contact: ____________

____________ *Telephone: ____________

*City, state, zip: ____________ Fax: ____________

E-mail: ____________

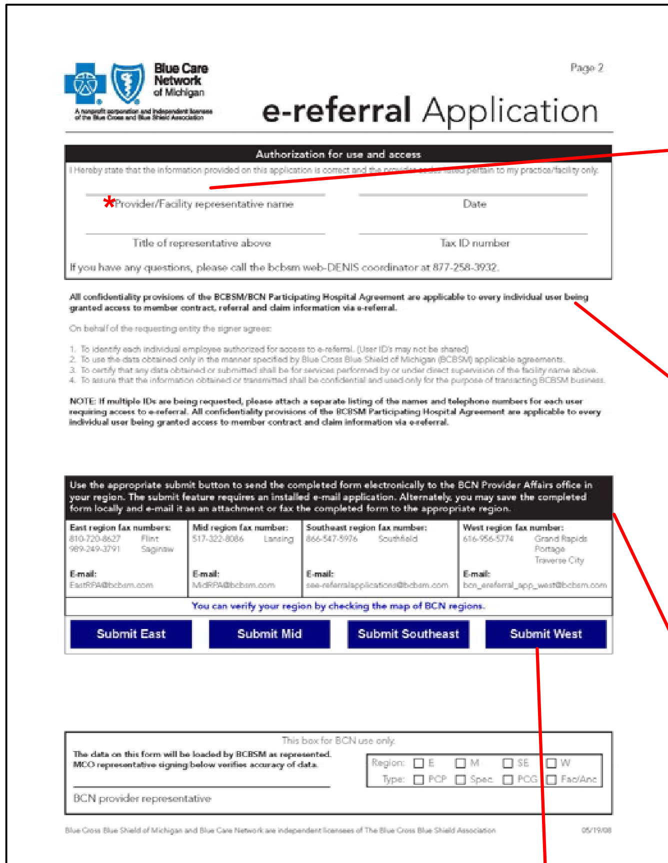
Physician offices: Please list the first and last names, and NPI codes for the physicians requesting e-referral access. Facilities: Please list the facility name and NPI codes for the facility requesting e-referral access:

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

continued on page 2



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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 appropriate submit button to send the completed form electronically to the BCN Provider Affairs office in your region. The submit feature requires an installed e-mail application. Alternately, you may save the completed form locally and e-mail it as an attachment or fax the completed form to the appropriate region.

East region fax numbers:	Mid region fax number:	Southeast region fax number:	West region fax number:
810-720-8627 Flint 989-249-3791 Saginaw	517-322-8086 Lansing	866-547-5976 Southfield	616-956-5774 Grand Rapids, Portage, Traverse City
E-mail: EastRPA@bcbsm.com	**E-mail:** MidRPA@bcbsm.com	**E-mail:** see-referralapplications@bcbsm.com	**E-mail:** bcn_ereferral_app_west@bcbsm.com

You can verify your region by checking the map of BCN regions.

Submit East | Submit Mid | Submit Southeast | Submit West

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

Region: ☐ E ☐ M ☐ SE ☐ W
Type: ☐ PCP ☐ Spec ☐ PCG ☐ Fac/Anc

Type Provider or Facility representative name here

Read the terms of the agreement. Do not submit the application if you do not agree to the terms.

IMPORTANT! HOW TO SUBMIT THIS FORM
- **Click Submit"**
- **E-mail**
- **Fax**

Type user's first name in this column

Type user's last name in this column

Type user's current web-DENIS address in this column (not required)

Go to Page 2 to complete the application

Click the Submit button for the appropriate BCN region.

Complete all fields marked with an asterisk. *
If you have questions about completing this form, please contact the BCBSM web-DENIS coordinator at 877-258-3932

How to complete and submit the e-referral Request for Group ID Changes form

Complete all fields marked by an asterisk (*)

Use this section to add or delete a USER

- Check box to add or delete user
- Type I-Exchange ID here
- Type user's first name here
- Type user's last name here

Use this section to add or delete a PROVIDER

- Check box to add or delete provider
- Type I-Exchange ID here
- Type provider's first name here
- Type provider's last name here

IMPORTANT NOTE

- Type user's practice name here
- Type user's current web-DENIS address here
- Type provider's 10-digit NPI here
- Complete this section to affirm the information on this form is correct.

IMPORTANT!
HOW TO SUBMIT THIS FORM
- Click "Submit"
- E-mail
- Fax

Click the Submit button for your region to send completed form

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Blue Care Network of Michigan

e-referral Request for Group ID Changes

* required fields

Date: ____________

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 appropriate submit button to send the completed form electronically to the BCN Provider Affairs office in your region. The submit feature requires an installed e-mail application. Alternately, you may save the completed form locally and e-mail it as an attachment or fax the completed form to the appropriate region.

East region fax numbers:	Mid region fax number:	Southeast region fax number:	West region fax number:
810-720-8627 Flint 989-249-3791 Saginaw	517-322-8086 Lansing	866-547-5976 Southfield	616-956-5774 Grand Rapids, Portage, Traverse City
E-mail: EastRPA@bcbsm.com	**E-mail:** MidRPA@bcbsm.com	**E-mail:** see-referralapplications@bcbsm.com	**E-mail:** bcn_ereferral_app_west@bcbsm.com

You can verify your region by checking the map of BCN regions.

Submit East | Submit Mid | Submit Southeast | Submit West

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

05/19/08