Blue Cross Blue Shield Blue Care Network of Michigan

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

ADDENDUM "G"

Please complete electronically

Authorization for Provider Enrollment and Change Self-Service

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

Provider Enrollment and Change Self-Service Basic Access: Allows users to maintain group demographics and composition only.

Provider Enrollment and Change Self-Service Full Access: Allows users to maintain group demographics and composition plus the ability to enroll and add new practitioners to the group.

Each transaction creates an audit trail and provides user controlled demographic changes with the ability to check the status of your change requests online anytime with a few mouse clicks.

Provider Group Name:

Type 2 NPI(s):

_____ _____ _____ _____ _____

Provider Enrollment and Change Self-Service Access Request

Name (Type or Print Full Name of Each User)	Telephone Number	Provider Secured Services ID	Provider Enrollment and Change Self-Service **Basic** Access	Provider Enrollment and Change Self-Service **Full** Access	Claims Tracking and EFT
John Doe	**111-222-3333**	**P000000**	[X]	[ ]	[X]
			[ ]	[ ]	[ ]
			[ ]	[ ]	[ ]
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Provider Enrollment and Change Self-Service Authorization

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 on this Addendum 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.

Note: This is an Addendum to the Provider Secured Services Use and Protection Agreement and does not alter the terms set forth therein.

_____ _____

Name of Authorized Group Representative | Title of Authorized Group Representative

_____ _____

Signature of Authorized Group Representative | Date

Fax 800-495-0812 | **Questions 877-258-3932**