Subscriber New Enrollment, BCN Primary Care Physician Selection or Change of Status Form

Please read the following information before completing the attached New Subscriber Enrollment, BCN-Primary Care Physician Selection or Change of Status forms.

The information on this form and the following conditions are part of your contract with Blue Cross Blue Shield of Michigan or Blue Care Network of Michigan.

I am applying for coverage for myself and my family members identified on this application under my employer's or association's contract with BCBSM or BCN. Coverage begins on the date determined by BCBSM or BCN. When BCBSM or BCN accepts my application, I and covered members of my family are bound by the terms of BCBSM's and BCN's CERTIFICATES, RIDERS, OTHER COVERAGE DOCUMENTS, POLICIES and this application. I understand that the submission of false or misleading information or the omission of material information on this form may result in rejection of my enrollment or retroactive termination of my coverage.

Proof of eligibility: I agree to provide proof of my dependents' eligibility for coverage when requested by BCBSM or BCN.

Authorization: I appoint my employer or association to handle all matters of coverage. It may forward any agreed deductions for coverage from my wages. I am responsible for giving notice to my employer or association of changes in my status or my family's status that affect coverage, such as marriage, divorce, birth, Medicare entitlements, or death of someone covered under the policy. I authorize BCBSM or BCN or my primary care physician to obtain the medical records relating to me and my enrolled family members necessary for the coordination of our medical care, administration of my coverage with BCBSM or BCN and for other purposes necessary for BCBSM or BCN to fulfill its contractual and statutory obligations.

Release of information: I acknowledge that BCBSM or BCN requires me to provide my Social Security number. In applying for coverage, I and my enrolled family members agree to permit providers and others to release "protected health information" (as that term is used in the Health Insurance Portability and Accountability Act of 1996, as amended) to BCBSM or BCN for purposes of administering our coverage. Upon my request, BCBSM or BCN will tell me where the information was sent.

COBRA: If I am a member who is 19 years old and older, I will not be eligible for a waiver of any preexisting exclusion. If I have enrolled in a flexible spending account or health reimbursement arrangement through my employer, I authorize BCBSM or BCN to provide claims information pertaining to me and my covered dependents to the account administrator to facilitate reimbursement.

Group representative information: Group represents that the status change being requested is compliant with and permissible under applicable state and federal law, including the Patient Protection and Affordable Care Act.

Blue Care Network only

I and my enrolled family members agree that all of our medical services must be performed, prescribed, directed or authorized by our designated BCN primary care physicians except in the case of an immediate and unforeseen medical emergency when the time needed to contact our PCPs may mean permanent damage to our health. Unauthorized services that are not an emergency, as described above, received from non-BCN providers will not be covered.

The BCN service area excludes Branch, Lake, Lenawee, Mason, Missaukee, Osceola and Sanilac counties. Residents of these counties may receive nonemergent services in a BCN-covered county.

I agree to assign to BCN my entire right of recovery of the cost of hospital, medical and prescription services delivered by or paid for by BCN against any person or organization as a result of accident or disease including injuries or disease claimed under workers compensation laws or acts, whether by redemption award or voluntary payment or otherwise.

I authorize any holder of medical or other information about me or my enrolled family members to release to the Centers for Medicare and Medicaid Services, any insurance company, or any HMO and their agents, any information needed to determine benefits coverage. I request that payment of authorized Medicare, Medicaid, insurance company, or HMO benefits be made payable to BCN on my behalf for any services furnished to me and my enrolled family members by BCN.

Send completed forms to:

For Blue Cross Blue Shield of Michigan
Membership and Billing - M.C. 0519
Blue Cross Blue Shield of Michigan
P.O. Box 2260
Detroit, MI 48231-2260
Fax: 1-866-900-2619 or
1-866-900-2829

For Blue Care Network
Membership and Billing - M.C. C411
Blue Care Network
P.O. Box 5043
Southfield, MI 48086
Fax: 1-877-218-1466

Blue Cross Blue Shield Blue Care Network of Michigan

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

SUBSCRIBER NEW ENROLLMENT

(see Page 3 for instructions) ☐ BCBSM ☐ BCN Member - Complete Page 4 for PCP Selection

BCBSM group number ____ - Division ____ BCN group ID ____ Subgroup ID ____ Class ID ____ Employer representative signature ____ Date ____/____/____

Subscriber information

Social Security number (Required) ___ - ___ - ___ Subscriber last name ____ Subscriber first name ____ M.I. ____ Marital Status ☐ S ☐ M Gender ☐ M ☐ F Subscriber birth date ____/____/____

Home street address ____ City ____ State ____ ZIP Code ____

County ____ Country - if other than USA ____ ☐ Home ☐ Work ☐ Cell Primary phone ___ - ___ - ____ ☐ Home ☐ Work ☐ Cell Secondary phone ___ - ___ - ____

E-mail - optional ____

List all persons to covered:

	Last name	First name	MI	Gender	Date of birth	Social Security number	*Relationship code (see instructions for codes)
Spouse				☐ M ☐ F	/ /		
Dep. 1				☐ M ☐ F	/ /		
Dep. 2				☐ M ☐ F	/ /		
Dep. 3				☐ M ☐ F	/ /		
Dep. 4				☐ M ☐ F	/ /		

If the permanent address of the spouse or dependent is different from the address above, please complete the information below:

Spouse or dependent (full name) ____ Street address ____ City ____ State ____ ZIP code ____

Coordination of benefits information

Do you, your spouse or dependent(s) maintain other health coverage? ☐ Yes ☐ No If Yes, complete below: ☐ Check here if this applies to all members on the contract:

Person covered (full name)	Employer or group name	Policy number	Carrier	Address

I have read and understand the conditions of this form. Subscriber signature: ____ Date: ____/____/____

Health savings and flexible spending account options

☐ HSA ☐ HSA Opt out BCBSM Product indicator code: ____ ☐ FSAMED Goal amount: ____ ☐ FSADEPCA Goal amount: ____

Employer/Group use only

Group name: ____ Employee ID badge #: ____

Benefit code: ____ Plan code: ____ Date of hire: ____/____/____ Effective date: ____/____/____

Check coverage if applicable : ☐ Medical ☐ Dental ☐ Vision

Check type of enrollment: ☐ New ☐ Rehire ☐ Full time ☐ Part time ☐ Transfer ☐ Return from layoff ☐ Loss of eligibility (prior coverge) ☐ Retiree ☐ Hourly ☐ Salary ☐ Surviving spouse ☐ Open enrollment

Average hours worked per week (required): ____ Job title (required): ____

COBRA enrollment Check reason: ☐ Termination ☐ Reduction of hours ☐ Divorce or legal separation ☐ Layoff ☐ Loss of dependent status ☐ Deceased subscriber

Previous contract # ____ Original qualifying date ____/____/____

Loss of eligibility (prior coverage) ☐ Yes ☐ No If Yes, complete below:

Carrier's name (Including BCBSM and BCN): ____ Contract holder name ____ Policy# ____ Termination date: ____/____/____

Are any members listed enrolled in Medicare? ☐ No ☐ Yes If Yes, check reason category ☐ Working Aged ☐ Retired ☐ Disabled ☐ ESRD HIC#: ____

☐ Medicare primary ☐ BCBSM or BCN primary Medicare A effective date ____/____/____ Medicare B effective date ____/____/____ Medicare Part D effective date ____/____/____

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Reset

Instructions for completing *Subscriber New Enrollment* form on Page 2

- Indicate if enrolling in BCBSM or BCN: If enrolling with BCN, complete the *BCN Primary Care Physician Selection* form on Page 4 to designate your primary care physician.
- Enter BCBSM group and division number (for example, suffix, section code) or BCN group number, subgroup number and BCN class number. Have your employer's HR representative sign and date the *Employer signature* section.

Subscriber information:

- Enter subscriber Social Security number (required if 45 years of age or older). Enter subscriber last name, subscriber first name and middle initial. Indicate whether single or married, male or female. Enter subscriber date of birth.
- Enter home address beginning with street address, city, state and ZIP code. Enter e-mail address.
- Enter county name for home address, country name (if other than USA). Enter primary and secondary phone number and indicate if home, work or cell.
- List all persons to be enrolled. Enter names on appropriate line - Spouse, Dependent 1, 2, 3 and 4 as applicable. Complete additional forms if you have more than four dependents.
- Enter last name, first name, middle initial, male or female, date of birth, Social Security number (required if 45 years of age or older) and relationship code (see below).

Relationship codes:

N - Child (by birth or adoption)	A - Child adoption in process **	C - Court order coverage (QMCSO) **
S - Stepchild	L - Legal guardianship **	D - Disabled child ***
P - Principal support (BCN only)*	SD - Sponsored dependent *	M - Medicare

* = Attach documentation ** = Attach court order *** = Attach physician statement

- Enter the spouse's or dependent's permanent address if different from the address indicated above.

Coordination of benefits information

- Indicate yes or no if you, your spouse or dependent maintain other health care coverage. If yes, list complete name of person covered, group name, policy number, carrier name and address. If other health coverage applies to all members on the contract, check the applicable box.

Health savings and flexible spending account options:

- Check all applicable options and enter the goal amount. Enter the four digit BCBSM product indicator code.

FSAMED – Medical spending account	HSA – Health Savings Account
FSADEPCA – Dependent care flexible spending account	HSA – Health Savings Account opt out

Employer/Group use only

- Enter employer or group name and employee identification, badge or department number, if applicable. Enter benefit code (service code, package code). Enter plan code (BCBSM plan servicing this contract). Enter date of hire and effective date.
- Please check all applicable boxes to indicate coverage selected.
- Check type of enrollment (new, rehire, etc.). Indicate the average hours worked per week and the employee's job title. If enrolled in COBRA check the reason for COBRA. Indicate the previous contract number and the original qualifying date.
- For loss of eligibility (prior coverage), indicate Yes or No. If yes, please indicate the carrier name, contract holder name, policy number and termination date.
- Medicare status: Indicate if any members listed are enrolled in Medicare. If Yes, check the category under which the member is enrolled in Medicare. Indicate if Medicare is primary or if BCBSM or BCN is primary per mandatory secondary payer laws, and enter effective date of the Medicare Parts A, B and D coverage. Please attach a copy of the Medicare card.

Please provide all documentation for enrollment.

Blue Cross Blue Shield Blue Care Network of Michigan

BCN Primary Care Physician Selection (see Page 5 for instruction)

Subscriber Social Security number (required for age 45 and older)	BCN group number	Subgroup number	Class number

If you are enrolling in BCN, you need to select a primary care physician for you and each person on your contract. List your selection(s) on this form. You can choose a different primary care physician for each member of your family, or one to care for your entire family. If you elect to have one doctor for your entire family, you must select a family or general practice physician. You cannot choose a specialist as a PCP. You also need to fill out this form if you are already enrolled in BCN and have decided to change your PCP.

Need information about available primary care physicians?
Our website **MiBCN.com/find** provides the most current information on BCN-affiliated primary care physicians. You can search for a doctor by family practice, general medicine, internal medicine, internal medicine and pediatrics, pediatrics and preventive medicine, city or hospital group.

Member Information

	Member's last name, first name	Physician last name, first name	Physician's NPI#	Physician address	If changing PCPs, list reason	Seen in the last 12 months?
Subscriber						☐Yes ☐No
Spouse						☐Yes ☐No
Dep. 1						☐Yes ☐No
Dep. 2						☐Yes ☐No
Dep. 3						☐Yes ☐No
Dep. 4						☐Yes ☐No

Group/Employer's name:	Date you changed to this physician:
I have read and understand the conditions of this form. Subscriber signature:	Date: / /

Return this form to start your health care partnership
We encourage you to return this form as soon as you enroll so we can notify your doctor of your membership.

Fax your completed form to 1-877-218-1466.
Or, mail to:
Membership and Billing
Mail Code C411
Blue Care Network
P.O. Box 5043
Southfield, MI 48086-5043

Changing your primary care physician is limited to once every 30 days. **All changes become effective two business days after we receive this form — unless you request a later effective date.** You cannot select an earlier date when you change your primary care physician. If you change your primary care physician while you are being treated by a specialist, your new primary care physician must reauthorize the treatment you are receiving. Your treatment may not be covered until that occurs.

On an exception basis only, you may request to change your PCP effective immediately by calling the Physician Selection Line at 1-888-656-8276. TTY users call 1-800-257-9980.

Instructions for completing the *BCN Primary Care Physician Selection* form on Page 4

- Enter subscriber Social Security number, BCN group number, subgroup number and class number.
- Enter each member's last and first name, physician's last name and first name, physician's NPI number, physician's address and the reason for changing your PCP, if applicable. Indicate if the primary care physician has been seen in the last 12 months. You can find the physician's NPI number when searching for a doctor on **MiBCN.com/find.**
- Enter the employer's name and the date you changed to this physician.
- In the signature section, sign your full name and enter the date that you signed the form.

Note: Submit the *BCN Primary Care Physician* form with your *New Subscriber Enrollment* form when enrolling with BCN.

Blue Cross Blue Shield Blue Care Network of Michigan

Change of Status

☐ BCBSM ☐ BCN Member (see instructions on Page 7)

BCBSM group	Division	BCN group number	Subgroup number	Class number	Employer representative signature	Date
	—					

Subscriber information *Required field

Subscriber Social Security number (*Required)	Subscriber last name*	Subscriber first name*	M.I.*	Marital status*	Gender
				☐ S ☐ M	☐ M ☐ F

New home street address*	City*	State*	ZIP code*	E-mail*

County*	Country – if other than USA*	New primary phone* ☐ Home ☐ Work ☐ Cell	New secondary phone* ☐ Home ☐ Work ☐ Cell	* Indicate changes only	Relationship code (See instructions for codes)

List all persons to be added or deleted:

	Last name	First name	M.I.	Gender	Date of birth	Social Security number (Required)	Relationship code (See instructions for codes)
Spouse ☐Add ☐Delete				☐M ☐F			
Dep. 1 ☐Add ☐Delete				☐M ☐F			
Dep. 2 ☐Add ☐Delete				☐M ☐F			
Dep. 3 ☐Add ☐Delete				☐M ☐F			
Dep. 4 ☐Add ☐Delete				☐M ☐F			

If the permanent address of the spouse or dependent is different from the address above, please complete the following information:	Spouse or Dependent (full name)	Home street address	City	State	ZIP code

Coordination of benefits information

Do you, your spouse or dependents maintain other health coverage? ☐ Yes ☐ No If yes, complete below: ☐ Check here if this applies to all members on the contract.

Person covered (full name)	Group name	Policy number	Carrier	Address

I have read and understand the conditions of this form. Subscriber signature: Date:

Health savings and flexible spending account options

☐ FSAMED Effective date: _____ Goal amount: _____ ☐ HSA

☐ FSADEPCA Effective date: _____ Goal amount: _____ ☐ HSA opt out

BCBSM Product indicator code _____ ☐ Add ☐ Change ☐ Cancel

Employer/Group use only

Group name	Employe I.D. badge or department #	Benefit code	Plan code

Check reason for change below:

☐ Marriage ☐ Loss of eligibility (prior coverage)

☐ Dependents ☐ Name change ☐ Open enrollment

Date of event: _____ Effective date: _____

Check type of cancellation and reason below. Type: ☐ Contract ☐ Spouse ☐ Dependents

Reason: ☐ COBRA ☐ Death ☐ Left employment

☐ Divorce ☐ Dependent over age ☐ Other

☐ Retired ☐ Other insurance

Last date of coverage: _____

Loss of eligibility (prior coverage)? ☐ Yes ☐ No If Yes, complete below:

Carrier's name (includes BCBSM or BCN)	Contract holder name	Policy #	Termination date

Are any listed members enrolled in Medicare? ☐ No ☐ Yes If Yes, check category ☐ Over 65 and working ☐ Retired ☐ Disabled ☐ ESRD

☐ Medicare primary per MSP laws

☐ BCBSM or BCN primary per MSP laws

Medicare A effective date: _____ Medicare B effective date: _____ Medicare D effective date: _____ HIC #: _____

Instructions for completing *Change of Status* form on Page 6

- Indicate if enrolling in BCBSM or BCN. if BCN, complete the *BCN Primary Care Physician Selection* form on Page 4 if you're changing your PCP.
- Enter BCBSM group and division number (suffix, section code) or BCN group number, subgroup number and BCN class number. Have your employer's HR representative sign and date the *Employer signature* section.

Subscriber information:

- Enter subscriber Social Security number (required if 45 years of age or older). Enter subscriber last name, subscriber first name, and middle initial. Enter the marital status, if changing. Indicate if you are a male or female.
- Enter new home address beginning with street address, city, state and ZIP code. Enter your new e-mail address, if changing.
- Enter new county name for home address and country name (if other than USA). Enter new primary phone, if changing, and indicate if home, work or cell. Enter new secondary phone number and indicate if home, work or cell.
- List all persons to be added or deleted. Enter name(s) on appropriate line - Spouse, Dependent 1, 2, 3 and 4 as applicable. Complete additional forms if all your dependents do not fit on this form.
- Enter last name, first name, middle initial, male or female, date of birth, Social Security number (required if 45 years of age or older) and relationship code (see below).

Relationship codes:

N - Child (by birth or adoption)	A - Child adoption in process **	C - Court order coverage (QMCSO) **
S - Stepchild	L - Legal guardianship **	D - Disabled child ***
P - Principal support (BCN only)*	SD - Sponsored dependent *	M - Medicare

* = Attach documentation ** = Attach court order *** = Attach physician statement

- Enter the spouse's or dependent's permanent address if different from the address indicated above.

Coordination of benefits information:

- Indicate Yes or No if you, your spouse or dependent maintain other health care coverage. If Yes, list complete name of person covered, group name, policy number, carrier name and address. If other health coverage applies to all members on the contract, check the applicable box.

Health savings and flexible spending account options:

- Check all applicable options and enter the goal amount. Enter the four digit BCBSM product indicator code.

FSAMED – Medical spending account	HSA – Health Savings Account
FSADEPCA – Dependent care flexible spending account	HSA – Health Savings Account opt out

Employer/Group use only:

- Enter employer or group name, and employee identification, badge or department number, if applicable. Enter benefit code (service code, package code). Enter plan code (BCBSM plan servicing this contract). Enter date of hire and effective date.
- Indicate the reason for change. Check the applicable box.
- Check the appropriate type of cancellation and reason. For BCN only, complete this *Change of Status* form (Page 6) to cancel active coverage, and complete the *New Subscriber Enrollment* form (Page 2) to enroll in COBRA.
- For loss of eligibility (prior coverage), indicate Yes or No. If Yes, please indicate the carrier name, contract holder name, policy number and termination date.
- Medicare status: Indicate if any members listed are enrolled in Medicare. If Yes, check the category under which the member is enrolled in Medicare. Indicate if Medicare is primary or if BCBSM or BCN is primary per mandatory secondary payer laws, and enter effective date of the Medicare Parts A, B and D coverage. Please attach a copy of the Medicare card.

Please provide all documentation required for enrollment.