Blue Cross Blue Shield Blue Care Network of Michigan

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

Provider Secured Services ID Reassignment

Please complete electronically

Practice or Facility Name:			Contact Person:
Street Address and Suite Number:			Contact Person's Telephone and Extension:
City:	State:	ZIP Code:	Contact Person's Company Issued Email Address:

This form allows you to reassign an existing Provider Secured Services ID that is no longer being used by your practice to another user in your practice. List below each Provider Secured Services ID you would like to reassign, the previous user, the new user, and the new user's telephone number.

The access assigned to the current Provider Secured Services ID will be transferred to the new user. This includes, but is not limited to: Eligibility, Claims Tracking, Electronic Funds Transfer (EFT), Internet Claims Transmission (ICT), and Provider Enrollment Change Self-Service. The new user will be bound to the original terms and conditions of all access that has been acquired.
Note: Reassigned users with access to Provider Enrollment and Change Self Service understand, acknowledge, and attest to the original terms of the Addendum G, including the authority to maintain practitioner and provider group enrollment records for all Blue Cross Blue Shield of Michigan provider codes currently associated with the user as well as any future provider codes assigned.

Provider Secured Sevices ID	Previous User *must match current records*	New User	Telephone Number	Reassign	Reconnect	Disconnect
Example F000000	John B Doe	Jane Smith	248-222-1112 Ext. 231	X	X	X
				☐	☐	☐
				☐	☐	☐
				☐	☐	☐
				☐	☐	☐
				☐	☐	☐
				☐	☐	☐
				☐	☐	☐
				☐	☐	☐
				☐	☐	☐
				☐	☐	☐

If additional space is required, attach a separate listing that includes the Provider Secured Services ID, previous user, new user, and the user's telephone number.

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 above 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.
I addition, I understand that by signing above I have the company's designated authority to request and maintain minimum necessary web access and am responsible for complying with all terms and conditions contained within the Provider Secured Services Use and Protection Agreement. https://www.bcbsm.com/content/dam/public/Providers/Documents/help/faqs/use-and-protection-agreement-professional-facility.pdf

AUTHORIZATION FOR USE AND ACCESS

Authorized Signature
Handwritten Signature Only

Date

Type Name of the Authorized Individual

Title of Authorized Individual

For Questions Call 877-258-3932 **Send Fax to 800-495-0812**