

ECoS Forms — Instructions

New Subscriber Enrollment, Change of Status, or Primary Care Provider Selection



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

1 Select the appropriate forms

This packet includes three forms. See below to determine which form you should use.

New Subscriber Enrollment (page 3):

Use this form to enroll a subscriber in a new plan:

- During **open enrollment**
- As a **new hire**
- When **returning from layoff or rehired**
- Because subscriber has **lost eligibility** on another plan (loss of coverage). *If coverage is lost from an insurance carrier other than Blue Cross or BCN, a letter of credible coverage is required.*
- As a **retiree**
- When **surviving spouse** is eligible for enrollment as a new subscriber
- When a **spouse or dependent is enrolling in COBRA** as a new subscriber

Change of Status (page 5):

Use this form to make changes to an existing plan, such as:

- **Adding a dependent**, including a spouse or child
- **Removing a dependent**, including a spouse or child
- **Transferring subscriber to a new division/subgroup**
- **Changing or correcting personal information**, such as name, address, email or phone number.
- **Transferring an existing subscriber to a COBRA plan**

Primary Care Provider Selection (page 4)

Complete this form if:

- Subscriber is **enrolling in a BCN HMO plan or the Physicians Choice PPO plan**
- Subscriber, spouse or dependent is **changing PCP** — this can also be done conveniently online or in the Blue Cross app

2 Note the codes and documentation you will need

Use the codes below to complete sections B and D of the New Subscriber Enrollment or Change of Status forms.

Section B. Dependent information

Use codes below to indicate relationship.

- Spouse **SP**
- Domestic Partner* **DP**
- Child (by birth or adoption) **N**
- Stepchild **S**
- Child adoption in process** **A**
- Legal Guardianship** **L**
- Disabled child*** **D**
- Sponsored dependent* **SD**
- Foster child **FC**
- Court Order Coverage (QMCSO)** **C**

*Attach documentation

**Attach court order

***Attach provider statement

Section C. Other health care coverage

Members with other health care coverage can contact insurer to find the original effective date.

If any members are enrolled in Medicare, please attach a copy of the Medicare card.

Section E. Employer/Group use only

New subscriber enrollment/COBRA: For a spouse or dependent applying to be the subscriber on a COBRA plan, the duration is always 36 months. **Change of status/COBRA:** For an existing subscriber changing to a COBRA plan, where the qualifying event is termination, COBRA duration is 18 months. In certain circumstances, if a disabled subscriber and non-disabled family members are qualified beneficiaries, they are eligible for up to an 11-month extension of COBRA coverage, for a total of 29 months.

3 Complete the forms and send to Membership and Billing — Be sure that:

- **Employer representative** has signed New Enrollment or Change of Status form.
- **Subscriber** has read the contract conditions on page 2 and signed where indicated on each form.
- **All required documentation is attached.**

For Blue Cross Blue Shield of Michigan

Mail:
Blue Cross Blue Shield of Michigan
Membership and Billing – M.C. 6101
P.O. Box 2260
Detroit, MI 48226

Fax: 1-866-900-2619

Email:
GroupCustomerMembership@BCBSM.com

For Blue Care Network

Mail:
Blue Care Network
Membership and Billing – M.C. C300
P.O. Box 5043
Southfield, MI 48086

Fax: 1-877-218-1466

Email:
BCNGroupMembership@BCBSM.com

Subscriber Agreement

Please read the following information before completing the attached forms. The information on these forms 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 health care coverage with Blue Cross Blue Shield of Michigan or Blue Care Network, or I am modifying existing coverage for myself or enrolled family members. Coverage begins on the date determined by Blue Cross or BCN. When Blue Cross or BCN accepts my application or changes, my enrolled family members and I are bound by the terms of the Blue Cross or BCN certificates, riders, other coverage documents, policies and these forms. I understand that submitting false or misleading information or omitting material information on these forms may result in rejection of my changes or retroactive termination of my coverage.

Proof of eligibility: I agree to provide proof of my enrolled family members' eligibility for coverage when requested by Blue Cross or BCN.

Authorization: I appoint my employer or association to handle all matters of coverage. My employer may forward any agreed deductions for coverage from my wages. I am responsible for notifying 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 enrolled on the plan. I authorize Blue Cross or BCN or my primary care provider to obtain the medical records relating to me and my enrolled family members needed to coordinate our medical care, administer my Blue Cross or BCN coverage and for other purposes necessary for Blue Cross or BCN to fulfill its contractual and statutory obligations.

Health Insurance Portability and Accountability Act: If I lose my eligibility for coverage, I may be entitled to special enrollment rights under HIPAA. Blue Cross or BCN reserves the right to request written verification of the date of the event and reason for loss of eligibility from my previous group or carrier. HIPAA special enrollment rights do not preempt a new hire waiting period, which must first be satisfied. Termination of employment may qualify for special enrollment rights, but voluntary terminations of other health care coverage do not.

Release of health care information: I acknowledge that Blue Cross or BCN requires me to provide my Social Security number. In applying for coverage, My enrolled family members and I agree to permit health care providers and others to release "protected health information (as defined

in the Health Insurance Portability and Accountability Act of 1996) to Blue Cross or BCN for administering our coverage. Upon my request, Blue Cross or BCN will tell me where the information was sent. If I have enrolled in a flexible spending account or health reimbursement arrangement through my employer, I authorize Blue Cross or BCN to provide claim information pertaining to me and my enrolled family members to the account administrator to facilitate reimbursement.

Group representative information: The group confirms that the status change requested complies with and is permitted under applicable state and federal law, including the Patient Protection and Affordable Care Act.

Blue Care Network only

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

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

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

New Subscriber Enrollment

For BCN, or Physician Choice PPO, also complete page 4, Primary Care Provider Selection form

<input type="checkbox"/> Blue Cross Blue Shield of Michigan	
Blue Cross group number	Division

<input type="checkbox"/> Blue Care Network		
BCN group number	Subgroup number	Class number



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Employer representative signature **SIGN**

A. Subscriber information

<input type="checkbox"/> Non-U.S. citizen	Social Security /TIN number (required)	Subscriber legal last name	Subscriber legal first name	M.I.	Marital status <input type="checkbox"/> S <input type="checkbox"/> M	Gender/Sex <input type="checkbox"/> F <input type="checkbox"/> M
Subscriber birth date	Home street address	City	State	ZIP code		
County	Country - if other than USA	Primary telephone number <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell	Secondary telephone number <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell	Email		

B. Dependent information — List all family members to be covered. If you have more than four dependents, complete additional copies of this form.

	Legal last name	Legal first name	M.I.	Gender/Sex	Birth date	Non-U.S. citizen	Social Security/TIN number (required)	Relationship (see instructions for codes)
Spouse				<input type="checkbox"/> F <input type="checkbox"/> M		<input type="checkbox"/>		
Dep. 1				<input type="checkbox"/> F <input type="checkbox"/> M		<input type="checkbox"/>		
Dep. 2				<input type="checkbox"/> F <input type="checkbox"/> M		<input type="checkbox"/>		
Dep. 3				<input type="checkbox"/> F <input type="checkbox"/> M		<input type="checkbox"/>		
Dep. 4				<input type="checkbox"/> F <input type="checkbox"/> M		<input type="checkbox"/>		

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

Spouse or dependent (full name)	Street address	City	State	ZIP code
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C. Other health care coverage (Coordination of benefits and Medicare information)

Do you, your spouse or dependents have other health care coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, complete this section.	Person covered (full name)	<input type="checkbox"/> Check if this applies to all members on this contract		
	Employer or group name	Policy number	Insurer	Original effective date
Are any members listed enrolled in Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, check category: <input type="checkbox"/> Over 65 and working <input type="checkbox"/> Retiree <input type="checkbox"/> Disabled <input type="checkbox"/> ESRD		
<input type="checkbox"/> Medicare primary <input type="checkbox"/> Blue Cross or BCN primary	<input type="checkbox"/> Subscriber <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent: _____	Medicare A effective date	Medicare B effective date	Medicare D effective date

I have read and understand the conditions of this form Subscriber signature **SIGN** Date _____

D. Health savings, health reimbursement and flexible spending account options - Blue Cross coverage only. See page 1 instructions for product codes.

Select account option: HRA HSA FSA FSA goal amount _____ Opt out Blue Cross product indicator code: _____

E. Employer/Group use only

Group name	Employer reference ID	Department ID	Benefit code	Plan code	Hire date	Effective date
Check coverage if applicable: <input type="checkbox"/> Medical <input type="checkbox"/> Vision <input type="checkbox"/> Dental <input type="checkbox"/> Pharmacy	Check enrollment type: <input type="checkbox"/> Open enrollment <input type="checkbox"/> New hire <input type="checkbox"/> Rehire <input type="checkbox"/> Return from layoff <input type="checkbox"/> Surviving spouse <input type="checkbox"/> Retiree					<input type="checkbox"/> Salary <input type="checkbox"/> Hourly
	<input type="checkbox"/> Loss of eligibility (prior coverage) Insurer's name (including Blue Cross & BCN) _____ Policy number _____ Contract holder _____ Termination date _____					<input type="checkbox"/> Full time <input type="checkbox"/> Part time
	<input type="checkbox"/> COBRA (36 mos.) <input type="checkbox"/> Termination <input type="checkbox"/> Reduction of hours <input type="checkbox"/> Divorce or legal separation Check reason: <input type="checkbox"/> Layoff <input type="checkbox"/> Deceased subscriber <input type="checkbox"/> Loss of dependent status					Previous contract number _____

Primary Care Provider Selection

Use this form to choose or change primary care providers for your BCBSM Physician Choice PPO or BCN HMO.



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Choose a primary care provider at enrollment

If you are enrolling in Blue Cross Blue Shield of Michigan Physician Choice PPO or Blue Care Network, you must select a primary care provider for yourself and each person on your contract. If you have more than four dependents, use additional copies of this form.

- You can choose a single PCP for your entire family, or different PCPs for different family members.
- Only family or general practice providers can serve as a PCP for the entire family.
- You cannot choose a specialist as your PCP.
- Subscribers must provide their Social Security number, if they are U.S. citizens, or tax identification number (TIN) if they are non-U.S. citizens.

Change your primary care provider

You may also change your primary care provider by logging onto your bcbsm.com account or using the bcbsm.com mobile app.

- If using this form, 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.
- If you change your primary care provider while being treated by a specialist, your new primary care provider must reauthorize the treatment you're receiving. Your treatment may not be covered until that occurs. You may ask to change your primary care provider effective immediately by calling the Customer Service number on the back of your Blue Cross or BCN ID card.

<input type="checkbox"/> Non-U.S. citizen	Subscriber Social Security/TIN number (required)	BCN/Blue Cross group number	BCN subgroup/Blue Cross division number	BCN class number
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Member Information						
	Member last name, first name	Provider last name, first name	Provider's NPI# <small>Can be found on bcbsm.com/find-a-doc</small>	Provider address	If changing PCPs, list reason	Seen in the last 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No
Subscriber						<input type="checkbox"/> Yes <input type="checkbox"/> No
Spouse						<input type="checkbox"/> Yes <input type="checkbox"/> No
Dep. 1						<input type="checkbox"/> Yes <input type="checkbox"/> No
Dep. 2						<input type="checkbox"/> Yes <input type="checkbox"/> No
Dep. 3						<input type="checkbox"/> Yes <input type="checkbox"/> No
Dep. 4						<input type="checkbox"/> Yes <input type="checkbox"/> No

Group/Employer name	Effective date of change:
I have read and understand the conditions of this form.	Subscriber signature SIGN
	Signature date

Need information about available primary care providers?

Our website, bcbsm.com/find-a-doctor, provides the most current information on Blue Cross and BCN-affiliated primary care providers, including the NPI# required above. You can search for a family practice, general medicine, internal medicine, pediatrics, preventive medicine, city or hospital group.

For Blue Cross Blue Shield of Michigan:

Mail completed form to:
 Blue Cross Blue Shield of Michigan
 Membership and Billing – M.C. 610I
 P.O. Box 2260
 Detroit, MI 48226

Fax to **1-866-900-2619**

For Blue Care Network:

Mail completed form to:
 Blue Care Network
 Membership and Billing – M.C. C300
 P.O. Box 5043
 Southfield, MI 48086-5043

Fax to **1-877-218-1466**

Change of Status

Use this form to change personal information, add or delete a member, transfer division or transfer an existing subscriber to COBRA.

<input type="checkbox"/> Blue Cross Blue Shield of Michigan	
Blue Cross group number	Division

<input type="checkbox"/> Blue Care Network		
BCN group number	Subgroup number	Class Number



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Employer representative signature **SIGN**

Date

A. Subscriber information — Fill in the fields marked with an asterisk only if the information has changed

<input type="checkbox"/> Non-U.S. citizen	Social Security /TIN number (required)	Subscriber legal last name	Subscriber legal first name	M.I.*	Marital status* <input type="checkbox"/> S <input type="checkbox"/> M	Gender/Sex* <input type="checkbox"/> F <input type="checkbox"/> M
Subscriber birth date	New home street address*		City*	State*	ZIP code*	
County*	Country* - if other than USA	Primary telephone #* <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell	Secondary telephone #* <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell	Email*		

B. Dependent information — List all family members to be covered. If you have more than four dependents, complete additional copies of this form.

	Legal last name	Legal first name	M.I.	Gender/Sex	Birth Date	Non-U.S. citizen	Social Security/TIN number (required)	Relationship (see instructions for codes)
Spouse <input type="checkbox"/> Add <input type="checkbox"/> Delete				<input type="checkbox"/> F <input type="checkbox"/> M		<input type="checkbox"/>		
Dep. 1 <input type="checkbox"/> Add <input type="checkbox"/> Delete				<input type="checkbox"/> F <input type="checkbox"/> M		<input type="checkbox"/>		
Dep. 2 <input type="checkbox"/> Add <input type="checkbox"/> Delete				<input type="checkbox"/> F <input type="checkbox"/> M		<input type="checkbox"/>		
Dep. 3 <input type="checkbox"/> Add <input type="checkbox"/> Delete				<input type="checkbox"/> F <input type="checkbox"/> M		<input type="checkbox"/>		
Dep. 4 <input type="checkbox"/> Add <input type="checkbox"/> Delete				<input type="checkbox"/> F <input type="checkbox"/> M		<input type="checkbox"/>		

If the permanent address of the spouse or dependent is different from the subscriber address above, please provide here:	Spouse or dependent (full name)	Home address	City	State	ZIP code
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C. Other health care coverage (Coordination of benefits and Medicare information)

Do you, your spouse or dependents have other health care coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, complete this section.	Person covered (full name)	<input type="checkbox"/> Check if this applies to all members on this contract			
	Employer or group name	Policy number	Insurer	Original effective date	

Are any members listed enrolled in Medicare? Yes No If yes, check category: Over 65 and working Retiree Disabled ESRD Medicare ID _____

<input type="checkbox"/> Medicare primary	<input type="checkbox"/> Subscriber <input type="checkbox"/> Spouse	Medicare A effective date	Medicare B effective date	Medicare D effective date
<input type="checkbox"/> Blue Cross or BCN primary	<input type="checkbox"/> Dependent: _____			

I have read and understand the conditions of this form Subscriber signature **SIGN** Date

D. Health savings, health reimbursement and flexible spending account options - Blue Cross coverage only. See instructions for product selection codes

<input type="checkbox"/> HRA <input type="checkbox"/> HSA <input type="checkbox"/> FSA FSA goal amount _____ <input type="checkbox"/> Opt out	Blue Cross product indicator code: _____	<input type="checkbox"/> Add/Change <input type="checkbox"/> Cancel
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E. Employer/Group use only

Group name	Employer Reference ID	Department ID	Benefit code	Plan code
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Type of change: <input type="checkbox"/> Name <input type="checkbox"/> Address <input type="checkbox"/> Add member <input type="checkbox"/> Benefit change <input type="checkbox"/> Transfer: new division/subgroup _____ <input type="checkbox"/> Subscriber COBRA enrollment: <input type="checkbox"/> 18 <input type="checkbox"/> 29 mos.	Event date	Cancellation: check type <input type="checkbox"/> Contract <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent Check reason: <input type="checkbox"/> Left employment <input type="checkbox"/> Retired <input type="checkbox"/> Death <input type="checkbox"/> Divorce <input type="checkbox"/> Other insurance <input type="checkbox"/> Dependent over age <input type="checkbox"/> Other Last date of coverage _____
Loss of eligibility (prior coverage): <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, complete below Insurer (including Blue Cross & BCN) _____ Policy number _____ Contract holder _____ Termination date _____	Effective date	

