

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

To view and update membership electronically, use eMVP and eMCS on the Group or Agent Portal – the fastest way to update membership records.

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**
- 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.

Section D. Health savings, health reimbursement and flexible spending account options

Do not complete for Blue Care Network members. If the plan offers HSA, HRA or FSA accounts and you are enrolling in one, use the codes below to indicate the account type you have selected.

HSA only **1000**

HSA with limited purpose FSA **1070**
HSA with dependent care FSA **1004**
HSA with limited purpose FSA & dependent care FSA **1074**
HSA with limited purpose HRA **1600**
HSA Opt Out - High deductible plan without HSA **0000**

HRA only **0100**

HRA with limited purpose FSA **0170**
HRA with dependent care FSA **0104**
HRA with limited purpose FSA & dependent care FSA **0174**
HRA with health care FSA **0110**
HRA with health care FSA & dependent care FSA **0114**

Health care FSA **0010**

Dependent care FSA **0004**
Health care and dependent care FSA **0014**
PPO without Health care FSA **0000**

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. J 202
P.O. Box 312260
Detroit, MI 48231

Fax: 1-866-900-2619

Email:

GroupCustomerMembership@bcbsm.com

For Blue Care Network

Mail:

Blue Care Network
Membership and Billing – M.C. J 207
P.O. Box 44257
Detroit, MI 48244-0257

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, also complete page 4,
Primary Care Provider Selection form

☐ Blue Cross Blue Shield of Michigan

Blue Cross group number

Division

☐ Blue Care Network

BCN group number

Subgroup number

Class number



Employer representative signature **SIGN**

A. Subscriber information

☐ Non-U.S. citizen

Social Security /TIN number (required)

Subscriber legal last name

Subscriber legal first name

M.I.

Marital status

☐ S ☐ M

Gender/Sex

☐ F ☐ M

Subscriber birth date

Home street address

City

State

ZIP code

County

Country - if other than USA

Primary telephone number

☐ Home
☐ Work
☐ Cell

Secondary telephone number

☐ Home
☐ Work
☐ 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				☐ F ☐ M		☐		
Dep. 1				☐ F ☐ M		☐		
Dep. 2				☐ F ☐ M		☐		
Dep. 3				☐ F ☐ M		☐		
Dep. 4				☐ F ☐ M		☐		

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

C. Other health care coverage (Coordination of benefits and Medicare information)

Do you, your spouse or dependents have other health care coverage?

☐ Yes ☐ No

If yes, complete this section.

Person covered (full name)

☐ 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

☐ Medicare primary

☐ Subscriber ☐ Spouse

Medicare A effective date

Medicare B effective date

Medicare D effective date

☐ Blue Cross or BCN primary

☐ 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 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:

☐ Medical
☐ Vision
☐ Dental
☐ Pharmacy

Check enrollment type:

☐ Open enrollment ☐ New hire ☐ Rehire ☐ Return from layoff ☐ Surviving spouse ☐ Retiree

☐ Loss of eligibility (prior coverage)

Insurer's name (including Blue Cross & BCN)

Policy number

Contract holder

Termination date

☐ COBRA (36 mos.)
Check reason: ☐ Termination ☐ Reduction of hours ☐ Divorce or legal separation ☐ Layoff ☐ Deceased subscriber ☐ Loss of dependent status

Previous contract number

Original qualifying date

☐ Salary ☐ Hourly

☐ Full time ☐ Part time

Page 3 of 6 | WF 18678 NOV 25

Primary Care Provider Selection

Use this form to choose or change primary care providers for your BCN HMO.



Choose a primary care provider at enrollment

If you are enrolling in 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 Blue Cross 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 BCN ID card.

☐ Non-U.S. citizen	Subscriber Social Security/TIN number (required)	BCN group number	BCN subgroup	BCN class number
---	--	------------------	--------------	------------------

Member Information						
	Member last name, first name	Provider last name, first name	Provider's NPI# <i>Can be found on Find a Doctor or Facility</i>	Provider 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 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, **Find a Doctor or Facility**, 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 Care Network:

- ✉ Mail completed form to:
Blue Care Network
Membership and Billing – M.C. J 207
P.O. Box 44257
Detroit, MI 48244-0257
- ✉ 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.

☐ Blue Cross Blue Shield of Michigan	
Blue Cross group number	Division

☐ Blue Care Network		
BCN group number	Subgroup number	Class Number



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

Employer representative signature **SIGN**

Date

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

☐ Non-U.S. citizen	Social Security /TIN number (required)	Subscriber legal last name	Subscriber legal first name	M.I.*	Marital status* ☐ S ☐ M	Gender/Sex* ☐ F ☐ M
Subscriber birth date	New home street address*		City*		State*	ZIP code*
County*	Country* - if other than USA	Primary telephone number*	☐ Home ☐ Work ☐ Cell	Secondary telephone number*	☐ Home ☐ Work ☐ 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 ☐ Add ☐ Delete				☐ F ☐ M		☐		
Dep. 1 ☐ Add ☐ Delete				☐ F ☐ M		☐		
Dep. 2 ☐ Add ☐ Delete				☐ F ☐ M		☐		
Dep. 3 ☐ Add ☐ Delete				☐ F ☐ M		☐		
Dep. 4 ☐ Add ☐ Delete				☐ F ☐ M		☐		
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

C. Other health care coverage (Coordination of benefits and Medicare information)

Do you, your spouse or dependents have other health care coverage? ☐ Yes ☐ No If yes, complete this section.	Person covered (full name)		☐ 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
☐ Medicare primary ☐ Blue Cross or BCN primary	☐ Subscriber ☐ Spouse ☐ 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 instructions for product selection codes

☐ HRA ☐ HSA ☐ FSA FSA goal amount _____ ☐ Opt out	Blue Cross product indicator code: _____	☐ Add/Change ☐ Cancel
---	--	---

E. Employer/Group use only

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

