# ECoS Forms — Instructions

#### Blue Cross Blue Shield Blue Care Network of Michigan

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

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

# 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 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

### 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. 610I P.O. Box 2260 Detroit, MI 48226

Fax:

1-866-900-2619

#### 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

#### Blue Cross Blue Shield Blue Care Network of Michigan

# **Subscriber Agreement**

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

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

☐ Blue Cross Blue Shield	of Michigan	☐ Blue Care Network	☐ Blue Care Network									
Blue Cross group number	Division	BCN group number	Subgroup number	Class number								
Employer representative signature SIGN												



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

A. Subso	criber in	formation																	
☐ Non-U.	S. citizen	Social Secu	ırity /T	IN number (requi	subscriber legal last name						Subscriber	Subscriber legal first name M.I					1.I.   Marital status   Gender/Sex     □ S □ M □ F □ M		
Subscribe	birth date	Home st	reet a	ddress						City	•		State		ZIP cod	de			
Country - if other than USA			Primary te		Home Secondary telephon				Home		il								
							☐ Work ☐ Cell				∐ Work □ Cell								
B. Depe	ndent in	formation	— Lis	st all family me	embers to be covered. If you have more than									copies of	this for	m.			
Legal last name			Legal first name			M.I. Gen			Birth date	Non-U.S.	Soci	al Securit	y/TIN	F		nship (see			
												citizen	num	<b>ber</b> (requir	red)		instructions for codes)		
Spouse										М									
Dep. 1										М									
Dep. 2										□ M □ M									
Dep. 3									□ F										
Dep. 4	lanent ado	trace of the s	nouse	or dependent is	different from	n the subscriber addre	se ahov	a nlas			e information b								
		nt (full name)	pouso	Street address	amoroni noi	The Subscriber address	,00 abov	o, picc	200 001	City	o imorriation b	010 11.			State			ZIP code	
	·	,																	
C. Other	health	care cover	age	Coordination	of benefi	ts and Medicare in	nforma	tion)											
		e or depend are coverag		Person covered	(full name)						Check	Check if this applies to all members on this contract							
Yes If yes, com	_	section.		Employer or gro	oup name			Policy number			Insurer	Insurer				Original effective date			
	<u> </u>		d in M	ledicare? Ye	s 🗌 No	If yes, check category	: 🗆 Ov	er 65 a	and wo	orking [	Retiree	Disabled [	ESRD	Medic	are ID				
Medica				ıbscriber Spo							Medicare A effe	ective date	Medica	are B effec	tive date	Medio	care D e	effective date	
Blue Cr	. ,			ependent:	Juse														
I have rea	d and und	lerstand the	cond	itions of this for	m Subsc	riber signature SIGN											Date		
D. Healt	h saving	s, health r	eimb	ursement and	d flexible s	spending account	option	ıs - B	lue C	ross co	verage only	. See page	1 inst	ructions	for prod	luct co	des.		
Select acc	ount optic	n: HRA		HSA FSA	FSA goal a	amount			Opt o	ut Blu	ue Cross produc	ct indicator o	code:						
E. Emplo	yer/Gro	up use on	ly																
Group nan	ne			Employer refer	ence ID [	Department ID		Ben	efit co	de	Plan cod	е		Hire date			Effectiv	e date	
Check cov		heck enrollr	nent t	ype: Open e	nrollment	■ New hire ■ Reh	nire 🗀	Retur	rn from	layoff	Surviving sp	spouse Retiree					☐ Salary ☐ Hourly		
Medical Loss of eligibility Insurer's name (including Blue Cross & BCN) Policy number										]	_ Full time								
Vision		(prior cove	rage)	Contract holde								Termination date				Part time			
Dental	F	COBRA (36	S mor			luction of hours	Div	orce o	r legal	separation		contract nui	mber			Origin	nal quali	fying date	
☐ Pharmacy Cobra (36 mos.) ☐ Termination ☐ Reduction of nours ☐ Divorce or legal separation ☐ Check reason: ☐ Layoff ☐ Deceased subscriber ☐ Loss of dependent status																			

# **Primary Care Provider Selection**

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

#### Blue Cross Blue Shield Blue Care Network of Michigan

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

### 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.

Non-U.S	S. Subscriber Social Security/Tilv II	umber (requir	ed) BON/Blue O	ross group number	BON Subgroup/Blue	e Cross division number	DON Class number	
Member In	formation							
	Member last name, first name Provider I		ist name, first name	Provider's NPI# Can be found on bcbsm.com/find-a-doc	Provider address	If changing reason	PCPs, list	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
							I = 0	
Group/Emp	ployer name						Effective date of	change:
I have read	d and understand the conditions of	this form.	Subscriber signature SI	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. 610l 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.

Blue Cross Blue Shield o	f Michigan	☐ Blue Care Network					
Blue Cross group number Division		BCN group number	Subgroup number	Class Number			
mplayer representative signature SIGN							



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

subscriber to CO	BRA.	3	Employe	r represent	tative s	signature [	SIGN						Date			of the	Blue Cros	and Blue Sl	nield Association
A. Subscribe	r info	ormation — Fil	II in the fie	lds mark	ed wit	th an aste	erisk only i	f the inforn	nation	has cl	nanged	t							
☐ Non-U.S. citi	zen	Social Security /T	IN number (	(required)	Su	ubscriber le	legal last name					Subscriber legal first name					Marital	status*	Gender/Sex
Subscriber birth	date	New home stre	et address*							City*	,					State		ZIP cod	
County*	Country* - if other than USA Primary telephone #*		ne #* 🗌 F	Home Work Cell Secondary telepho				lephone	#* Home	Email*	Email*								
B. Dependen	t inf	ormation — Lis	st all famil	y membe	ers to	be cover	red. If you	have more	than f	our de	pende	nts, comple	te additio	onal c	opies of	f this f	orm.		
	Lega	al last name		-	Lega	l first nam	пе		M.I.	Gend	er/Sex	Birth Date	Non-U	-	ocial Secumber (r				nship (see ons for codes
Spouse										□F	М								
Dep. 1 ☐ Add ☐ Delete										□F	ΠМ								
Dep. 2 ☐ Add ☐ Delete										□F	М								
Dep. 3 ☐ Add ☐ Delete										□F	Μ								
Dep. 4 ☐ Add ☐ Delete										□F	М								
		ess of the spouse			rent S	Spouse or	dependent (	full name)	Н	ome ad	dress		·	City			Sta	te	ZIP code
C. Other hea	lth c	are coverage	(Coordina	ition of b	enefi	its and N	/ledicare i	nformation	າ)			'		<u> </u>					'
Do you, your sp have other hea		or dependents re coverage?	Person co	vered (full	name)							Check if t	nis applies	to all r	nembers	on this	contrac	t	
Yes No If yes, complete	this s	ection.	Employer	or group n	ame			Policy num	ber			Insurer					Origina effecti	al ve date	
Are any member	ers lis	ted enrolled in M	ledicare?	Yes [	No	If yes, che	eck category	r: Over 6	5 and w	orking/	Re	tiree Disa	abled $\square$	ESRD	Medic	care ID			
Medicare pri	,		ubscriber [	Spouse							Medi	icare A effecti	ve date   N	/ledica	re B effec	tive da	te Me	dicare D	effective dat
☐ Blue Cross o		erstand the cond	ependent: _		0.1	., .	· GION								,			Date	
		s, health reimb					ature SIGN		Dlug (	24000	001/04/	ogo only C	oo inatru	otiono	for pro-	duet e	alaatia		
□ HRA □ H		·			XIDIE :	-	Opt out					icator code:	e mstru	Stions			/Change		
E. Employer/		☐ FSA FSA g	joai amount				Opt out	-	Side Oic		Juct IIIui					Add,	Change	e Ca	ıncei
Group name	GIOC	ap use only					Employer F	Reference ID				Departm	ent ID		Benefit	code	F	lan code	
Type of change	: 🗆 :	Name	ss 🗌 Add	member	Ве	enefit chan	ge			E۱	ent date	Cancella	tion: chec	k type	Cont	tract [	Spous	se 🔲 [	)ependent
☐ Transfer: nev	v divis	sion/subgroup		[	Subsc	criber COB	RA enrollme	ent: 🗌 18 📗	29 mos	s.		Check re	ason:					_	
_		ior coverage):					Policy numb	per			fective ite				☐ Retired ☐ Death ☐ Divorce ☐ Dependent over age ☐ Other				e
Insurer (including Blue Cross & BCN) Policy number Contract holder Termination date											Last date	Last date of coverage							

## We speak your language

If you, or someone you're helping, needs assistance, you have the right to get help and information in your language at no cost. To talk to an interpreter, call the Customer Service number on the back of your card.

Si usted, o alguien a quien usted está ayudando, necesita asistencia, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al número telefónico de Servicio al cliente, que aparece en la parte trasera de su tarjeta.

إذا كنت أنت أو شخص آخر تساعده بحاجة لمساعدة، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك دون أية تكلفة. للتحدث إلى مترجم اتصل برقم خدمة العملاء الموجود على ظهر بطاقتك.

如果您,或是您正在協助的對象,需要協助,您 有權利免費以您的母語得到幫助和訊息。要洽詢 一位翻譯員,請撥在您的卡背面的客戶服務電話

کی بخسلان کی بند فئی فیم دومته به با به بندید کی بختی به بازی که بازی کا به بند فئی به بازی کا به بازی کا به به بازی کا بازی کا به بازی کا بازی کا به بازی کا بازی کار کا بازی کا بازی

Nếu quý vị, hay người mà quý vị đang giúp đỡ, cần trợ giúp, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi số Dịch vụ Khách hàng ở mặt sau thẻ của quý vị.

Nëse ju, ose dikush që po ndihmoni, ka nevojë për asistencë, keni të drejtë të merrni ndihmë dhe informacion falas në gjuhën tuaj. Për të folur me një përkthyes, telefononi numrin e Shërbimit të Klientit në anën e pasme të kartës tuaj.

만약 귀하 또는 귀하가 돕고 있는 사람이 지원이 필요하다면, 귀하는 도움과 정보를 귀하의 언어로 비용 부담 없이 얻을 수 있는 권리가 있습니다. 통역사와 대화하려면 귀하의 카드 뒷면에 있는 고객 서비스 번호로 전화하십시오. যদি আপনার, বা আপনি সাহায্য করছেন এমন কারো, সাহায্য প্রয়োজন হয়, তাহলে আপনার ভাষায় বিনামূল্যে সাহায্য ও তথ্য পাওয়ার অধিকার আপনার রয়েছে। কোনো একজন দোভাষীর সাথে কথা বলতে, আপনার কার্ডের পেছনে দেওয়া গ্রাহক সহায্তা নম্বরে কল করুন।

Jeśli Ty lub osoba, której pomagasz, potrzebujecie pomocy, masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer działu obsługi klienta, wskazanym na odwrocie Twojej karty.

Falls Sie oder jemand, dem Sie helfen, Unterstützung benötigt, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer des Kundendienstes auf der Rückseite Ihrer Karte an.

Se tu o qualcuno che stai aiutando avete bisogno di assistenza, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, rivolgiti al Servizio Assistenza al numero indicato sul retro della tua scheda.

ご本人様、またはお客様の身の回りの方で支援を必要とされる方でご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合はお持ちのカードの裏面に記載されたカスタマーサービスの電話番号までお電話ください。

Если вам или лицу, которому вы помогаете, нужна помощь, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону отдела обслуживания клиентов, указанному на обратной стороне вашей карты.

Ukoliko Vama ili nekome kome Vi pomažete treba pomoć, imate pravo da besplatno dobijete pomoć i informacije na Vašem jeziku. Da biste razgovarali sa prevodiocem, pozovite broj korisničke službe sa zadnje strane kartice.

Kung ikaw, o ang iyong tinutulungan, ay nangangailangan ng tulong, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa numero ng Customer Service sa likod ng iyong tarheta.

## Important disclosure

Blue Cross Blue Shield of Michigan and Blue Care Network comply with Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. Blue Cross Blue Shield of Michigan and Blue Care Network provide free auxiliary aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and information in other formats. If you need these services, call the Customer Service number on the back of your card. If you believe that Blue Cross Blue Shield of Michigan or Blue Care Network has failed to provide services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance in person, by mail, fax, or email with: Office of Civil Rights Coordinator, 600 E. Lafayette Blvd., MC 1302, Detroit, MI 48226, phone: 888-605-6461, TTY: 711,

fax: 866-559-0578, email: <u>CivilRights@bcbsm.com</u>. If you need help filing a grievance, the Office of Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health & Human Services Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal available at <a href="https://ocrportal.hhs.gov/ocr/portal/lobby.isf">https://ocrportal.hhs.gov/ocr/portal/lobby.isf</a>, or by

mail, phone, or email at: U.S. Department of Health & Human Services, 200 Independence Ave, S.W., Washington, D.C. 20201, phone: 800-368-1019, TTD: 800-537-7697,

email: <a href="mailto:OCRComplaint@hhs.gov">OCRComplaint@hhs.gov</a>. Complaint forms are available at

http://www.hhs.gov/ocr/office/file/index.html.