Blue Cross
Blue Shield
Blue Care Network
of Michigan

FACILITY PROVIDER TERMINATION FORM

FAX OR MAIL COVER SHEET FOR DOCUMENTS

IMPORTANT: Attach this page to the top of your documents to avoid processing delays.

Fax To: **866-900-0250 Provider Enrollment**

From:

Date:

Mail to:

Blue Cross Blue Shield of Michigan
P.O. Box 217
Southfield, MI 48034

Form Number: 12889

Type 2 NPI:

Tax Identification Number:

Blue Cross Blue Shield Blue Care Network of Michigan

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

Facility Provider Termination Form

	Tax identification number	Type 2 National provider identifier

By executing this form, you are requesting Blue Cross Blue Shield of Michigan and Blue Care Network to terminate all your current network(s) and/or group affiliation(s). Upon completion of this request, you will no longer be able to bill BCBSM or BCN for services rendered to our subscribers and members.

Requested termination date: _____Where applicable, the actual termination date will be determined based on the execution provisions in the applicable participation/affiliation agreement(s).

Reason for termination:

Facility Provider information:

Facility name		
Primary Office Address		
Street address		
City	State	ZIP code
Primary telephone number	Fax number	
Facility Type		

Contact information:

*denotes a required field

Please provide the name and contact information of a person who can answer questions about information in this application.

*First name	*Last name
*Phone number	Fax number
E-mail	Preferred method of contact? ☐ E-mail ☐ U.S. Mail

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Provider Secured Services (web-DENIS) and Internet Claim Tool:

Complete the information below to update existing provider portal Web IDs to reflect this group/ allied provider's termination.	
Does the provider named above currently use Provider Secured Services (web-DENIS)?	☐ Yes ☐ No
Does this group/allied provider send claims through BCBSM's Internet Claim Tool?	☐ Yes ☐ No

Application signature:

*denotes a required field

I certify that the information contained in this application is true and complete. I will notify Blue Cross and Blue Shield of Michigan and Blue Care Network immediately in writing of changes affecting this data.

*Print or type name Authorized Representative's Name	*Authorized Representative's Signature	*Date