

Group Practice Agency Authorization And Acknowledgement Form

As a member of _____
(Group name)



A nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association

identified by _____
(National Provider Identifier) _____
(Group Provider Identification Number)

Name of authorized Group Representative: _____

Check one or both: Applies for Traditional (paragraph 1) Applies for BCN (paragraph 2)

I authorize the Group representative named above to act as my agent contracting with Blue Cross Blue Shield of Michigan (BCBSM) and have given this agent the authority to sign the Blue Cross Blue Shield of Michigan Practitioner Traditional Participation Agreement (CB 7669 JUL 09) (Agreement) on my behalf for covered services I provide(d) to BCBSM members, consistent with the terms and conditions of the Agreement. I agree that claims will be submitted only for covered services that are medically necessary and that I personally perform or directly supervise. I also agree that this is a continuing authorization and that information on claims' forms submitted by group representative have the same legal effect as if I had submitted it personally. I understand that I may withdraw this authorization and leave the Group at any time by giving 60 days prior written notice to the Group and to BCBSM. I agree to reimburse BCBSM for any losses that occur because of an action on the part of group representatives that results in an overpayment to the Group for services that I rendered.

I authorize the Group representative named above to act as my agent to contract with Blue Care Network of Michigan (BCN) and its subsidiary corporations, including but not limited to BCN Service Company (BSC), to provide health care services under health benefit products sponsored and/or administered by BCN, BSC or other BCN subsidiaries. By my signature below, I affirm that I am familiar with the "BCN Affiliation Agreement(s)" signed on my behalf by the Group representative. I agree to be bound by all terms and conditions of such Agreement(s), including applicable Provider Manuals and all amendments and modifications thereto. This includes but is not limited to BCN Member hold harmless requirements; BCN professional qualifications and credentialing standards; BCN fraud, waste and abuse policies; government sponsored health benefit products; and BCN administrative programs. Among these are policies related to quality management, medical management, network management, Member education, Member grievance, claims processing and administration, and clinical and nonclinical performance measurement and improvement. This Acknowledgement shall remain in effect for the term of the "BCN Affiliation Agreement(s)" or until I disaffiliate from Group or from BCN in accordance with termination provisions set forth in the "BCN Affiliation Agreement(s)".

1. _____ <i>Provider's Signature</i>	5. _____ <i>Provider's Signature</i>
_____ <i>Provider's Name/Degree (print or type)</i>	_____ <i>Provider's Name/Degree (print or type)</i>
2. _____ <i>Provider's Signature</i>	6. _____ <i>Provider's Signature</i>
_____ <i>Provider's Name/Degree (print or type)</i>	_____ <i>Provider's Name/Degree (print or type)</i>
3. _____ <i>Provider's Signature</i>	7. _____ <i>Provider's Signature</i>
_____ <i>Provider's Name/Degree (print or type)</i>	_____ <i>Provider's Name/Degree (print or type)</i>
4. _____ <i>Provider's Signature</i>	8. _____ <i>Provider's Signature</i>
_____ <i>Provider's Name/Degree (print or type)</i>	_____ <i>Provider's Name/Degree (print or type)</i>

Please attach additional sheets if necessary

Return this form along with the BCBSM/BCN Group Enrollment and Change Form and Traditional Participation Agreement Group Signature Document to:

Provider Enrollment and Data Management
Blue Cross Blue Shield of Michigan
P. O. Box 217
Southfield, MI 48034
or fax to 866-900-0250