

*Section 6: Blue Care Network
Enrollment/Change of Status form*



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Enrollment/Change of Status Form — Overview

About the Enrollment/Change of Status form

The ECOS form is used to report many routine membership changes, including:

- Enrollment
 - Termination
 - Contract changes
 - Name changes
 - Address changes
 - Reinstatement
 - COBRA
 - New physician selection
-

When to report changes

Enrollments, membership changes, qualifying events (births, marriages) and terminations must be reported within 30 calendar days of the effective date. Timely reporting ensures that subscribers and their dependents have coverage when they need it. It also ensures that you will not pay for coverage that is not used.

BCN will not accept retroactive terminations or additions from your group more than 30 calendar days after the member's change in status or the qualifying event. Additions and changes not reported within 30 calendar days of the event must be held until your group's next open enrollment period.

Patient Protection and Affordable Care Act

Your group represents that any eligibility and status changes it requests are compliant with and permissible under applicable state and federal law, including the Patient Protection and Affordable Care Act, and agrees that it will only request eligibility and status changes that are compliant with and permissible under applicable state and federal law, including the Patient Protection and Affordable Care Act.

Your group agrees to abide by all applicable state and federal law, including but not limited to the Patient Protection and Affordable Care Act,

Enrollment/Change of Status Form — Overview

(continued)

Submitting the ECOS form

Submit the form to BCN within the 30-day required time period to:
Membership — Mail Code C411
Blue Care Network
P.O. Box 5043
Southfield, MI 48086-5043

Note: Do not mail ECOS forms with your premium payment. This could delay processing.

For urgent enrollment requests, please contact Group Inquiry at 1-800-970-6684.

Processing the ECOS form

BCN begins processing ECOS forms as soon as they are received. If the form is complete and contains all BCN eligibility criteria, the member receives a BCN identification card and other member material within five to seven business days.

A BCN representative will notify you if the request cannot be processed for one of these reasons:

- The request arrived after the 30-day deadline.
- The data do not meet the eligibility criteria of BCN or the Group Enrollment and Coverage Agreement.
- The form was incomplete.
- The form was illegible.
- Supporting documentation was missing.
- The group representative signature is missing.

Subscriber new enrollment

Timing ✓ Submit an ECOS form within 30 calendar days to enroll the following individuals:

To Enroll	Coverage Effective Date	Additional Documents
Employers and owners	<ul style="list-style-type: none"> ✓ Effective date of new group or in accordance with the terms specified in the Group Enrollment and Coverage Agreement ✓ At annual open enrollment 	None
Full-time workers (full-time and contract) and dependents	<ul style="list-style-type: none"> ✓ Coverage for new hires and rehires is effective according to the terms specified in the Group Enrollment and Coverage Agreement. ✓ At annual open enrollment, provided the new hire/rehire period is met. 	None
Subscriber and dependents due to loss of coverage	<ul style="list-style-type: none"> ✓ Date of cancellation of the previous coverage with no lapse in coverage ✓ At annual open enrollment ✓ Must have satisfied new hire/rehire waiting period according to the Group Enrollment and Coverage Agreement. 	Letter from former health insurance carrier or group showing loss of coverage

Subscriber new enrollment (continued)

Timing Submit the ECOS form within 30 calendar days to enroll the following individuals:

To Enroll	Coverage Effective Date	Additional Documents
Subscriber and dependent transfers from other Michigan Blues products (new-hires only)	<ul style="list-style-type: none"> ✓ Date of hire/new hire waiting period may be waived at discretion of the group for those transferring directly from another Michigan Blues product 	None
Subscriber and dependents at open enrollment	<ul style="list-style-type: none"> ✓ Contact your Blues sales representative or agent for the specific date 	None
Spouse or dependent due to survivorship clause	<ul style="list-style-type: none"> ✓ Termination of subscriber contract ✓ Group must have survivorship clause approved by BCN 	Enrollment/ Change of Status form completed by surviving spouse
Subscriber who previously declined coverage	<ul style="list-style-type: none"> ✓ Date of cancellation of the previous coverage with no lapse in coverage ✓ At annual open enrollment ✓ Must have satisfied new hire/rehire waiting period according to the Group Enrollment and Coverage Agreement 	Letter from former health insurance carrier or group showing loss of coverage

Subscriber new enrollment (continued)

Timing ✓ Submit the ECOS form within 30 calendar days of effective date to enroll the following individuals:

To Enroll	Coverage Effective Date	Additional Documents
Subscriber and dependent who initially had other group coverage and the group contribution ceased	<ul style="list-style-type: none"> ✓ Date of cancellation of the previous coverage with no lapse in coverage ✓ At annual open enrollment ✓ Must have satisfied new hire/rehire waiting period according to the Group Enrollment and Coverage Agreement 	Letter from group indicating loss of contribution
Subscriber and dependent with dependent acquired through marriage, birth, adoption or placement for adoption	<ul style="list-style-type: none"> ✓ Date of event ✓ At annual open enrollment 	Adoption papers or documents verifying intent to adopt, if applicable

Using the ECOS Form to enroll new subscribers

ECOS form Complete page 2 of the ECOS form to enroll new subscribers.

Subscriber sections

The subscriber enters the following:

- Social Security Number, last name, first name, middle initial, marital status, gender and date of birth
- Street address, city, state and zip code
- County name for home address, country name (if other than USA)
- Primary and secondary phone number, indicating if these are home, work or cell phones
- All persons to be added (spouse, dependents), with names, gender, dates of birth, Social Security Numbers (required) and relationship codes

N – Child (by Birth or Adoption)

S – Stepchild

P - Principal Support

A – Child Adoption in Process (court order required)

L – Legal Guardianship (court order required)

SD – Sponsored Dependent (documentation required)

C – Court order coverage (QMCSO) (court order required)

D – Disabled Child (PA 275) (physician statement required)

M – Medicare

- Permanent address of spouse or dependents if different from the subscriber
- Coordination of Benefits Information, indicating if the subscriber, spouse or dependent maintains other health care coverage

After entering the information, the subscriber must sign and date the form in the signature section.

Using the ECOS form to enroll new subscribers (continued)

Group information at the top of the form

The group enters the following at the top of the page:

- BCN group identification number
- Subgroup identification number
- BCN class identification number.


The group representative must sign and date the form in the signature section.

Group information after subscriber section

These boxes follow the “Coordination of Benefits Information.”

- Group name, employee Identification/badge/department number, if applicable
- Date of hire and effective date
- Type of enrollment
- Average hours worked and job title
- COBRA information, if applicable
- If enrollment if due to loss of coverage
- Medicare status

Subscriber New Enrollment (ECOS Form, page 2)



SUBSCRIBER NEW ENROLLMENT
(see Page 3 for instructions)

BCBSM BCN Member - Complete Page 4 for PCP Selection

BCBSM group number

Division

BCN group ID

Subgroup ID

Class ID

Employer representative signature

Date

Subscriber Information

Social Security number (Required) -- Subscriber last name Subscriber first name M.I. Marital Status S M M F Subscriber birth date /

Home street address City State ZIP Code

County Country - if other than USA Home Work Cell Primary phone Home Work Cell Secondary phone

E-mail - optional

List all persons to be covered:

	Last name	First name	M	Gender	Date of birth	Social Security number	Relationship code (see instructions for codes)
Spouse				<input type="checkbox"/> M <input type="checkbox"/> F	/ /		
Dep. 1				<input type="checkbox"/> M <input type="checkbox"/> F	/ /		
Dep. 2				<input type="checkbox"/> M <input type="checkbox"/> F	/ /		
Dep. 3				<input type="checkbox"/> M <input type="checkbox"/> F	/ /		
Dep. 4				<input type="checkbox"/> M <input type="checkbox"/> F	/ /		

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

Spouse or dependent (M) name Street address City State ZIP code

Coordination of benefits information

Do you, your spouse or dependent(s) maintain other health coverage? Yes No If Yes, complete below: Check here if this applies to all members on the contract:

Person covered (M) name Employer or group name Policy number Carrier Address

I have read and understand the conditions of this form. Subscriber signature: Date: /

Health savings and flexible spending account options

HSA HSA Opt out Product indicator code: FSAMED Goal amount: FSADEPCA Goal amount:

Employer/Group use only

Group name: Employee ID badge #:

Benefit code: Plan code: Date of hire: / Effective date: /

Check coverage if applicable: Medical Dental Vision

Check type of enrollment: New Return from layoff Hourly Average hours worked per week (required): COBRA enrollment Termination Reduction of hours Divorce or legal separation

Rehire Loss of eligibility (prior coverage) Salary Job title (required): Check reason: Layoff Loss of dependent status Deceased subscriber

Full time Part time Transfer Retiree Surviving spouse Open enrollment Previous contract # Original qualifying date

Loss of eligibility (prior coverage) Yes No If Yes, complete below:

Carrier's name (including BCBSM and BCN): Contract holder name Policy# Termination date: /

Are any members listed enrolled in Medicare? No Yes If Yes, check reason category Working Aged Retired Disabled ESRD HC#:

Medicare primary Medicare A effective date Medicare B effective date Medicare Part D effective date

BCBSM or BCN primary

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Adding members

Timing ✓ Submit the ECOS form within 30 calendar days of effective date to add the following dependents to an existing contract:

To Add	Coverage Effective Date	Additional Documents
Spouse or dependent child	<ul style="list-style-type: none"> ✓ Date of marriage, birth ✓ Annual open enrollment 	None
Spouse or dependent due to loss of coverage	<ul style="list-style-type: none"> ✓ Loss of coverage date if reported within 30 calendar days with no lapse in coverage ✓ Annual open enrollment 	Letter from former health insurance carrier or group stating coverage has been terminated
Children by legal adoption or guardianship or petition for legal guardianship	<ul style="list-style-type: none"> ✓ Date of legal adoption, guardianship or petition filing ✓ Annual open enrollment 	<ul style="list-style-type: none"> ✓ Court order ✓ Documentation verifying guardianship (must be received within 12 months of filing petition) ✓ Documentation verifying intent to adopt ✓ Petition for guardianship
Principal support of dependent	<ul style="list-style-type: none"> ✓ Date that established nine-month criteria is met ✓ Annual open enrollment 	<ul style="list-style-type: none"> ✓ Most recent federal income tax return form <p>OR</p> <ul style="list-style-type: none"> ✓ Notarized statement verifying support if taxes have not yet been filed

Adding members (continued)

Timing ✓ Submit the ECOS form within 30 calendar days of effective date to add the following dependents to an existing contract:

To Add	Coverage Effective Date	Additional Documents
Returning military veterans	<ul style="list-style-type: none"> ✓ Date of discharge ✓ Annual open enrollment 	Proof of discharge
Qualified medical support order	<ul style="list-style-type: none"> ✓ Date of court order if received within 30 days; otherwise, date of receipt 	Copy of Qualified Medical Child Support Order or specified section of the Divorce Degree
Incapacitated or disabled children over age 26	<ul style="list-style-type: none"> ✓ Subscriber's initial effective date ✓ Annual open enrollment 	Physician's certificate prior to end of year dependent turns 26
Spouse or dependents due to the marriage, birth, adoption of another dependent	<ul style="list-style-type: none"> ✓ Date of event ✓ Annual open enrollment 	Adoption papers or documents verifying intent to adopt or petition for guardianship
Spouse or dependents due to a group-wide change	Date of the change	None
Spouse or dependents due to a change in the group contribution	Date of the change	Letter from group indicating change in contribution

Deleting members: Termination

Termination options

A member's coverage is effective until midnight of the termination date indicated on the Enrollment/Change of Status form. The following coverage termination options apply:

- ✓ **Contract Termination** — Cancels the coverage of the subscriber, spouse and dependents on the contract
 - ✓ **Spouse Termination** — Cancels the coverage of the spouse only
 - ✓ **Dependent Termination** — Cancels the coverage of the dependents listed.
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Timing

Please note: BCN must receive all terminations from your group within 30 days following the member's change in status or the effective date.

Patient Protection and Affordable Care Act

Your group represents that any eligibility and status changes it requests are compliant with and permissible under applicable state and federal law, including the Patient Protection and Affordable Care Act, and agrees that it will only request eligibility and status changes that are compliant with and permissible under applicable state and federal law, including the Patient Protection and Affordable Care Act.

Your group agrees to abide by all applicable state and federal law, including but not limited to the Patient Protection and Affordable Care Act,

Deleting members: Termination (continued)

Type of Termination	When to report	Termination Effective Date
Subscriber ✓ Termination ✓ Lay-off ✓ Reduced work hours ✓ No longer wants coverage ✓ Termination of COBRA	Within 30 calendar days of the event	Date of event or the group's personnel policy
Subscriber retirement	Within 30 calendar days of the event	Date of retirement
Subscriber death	Within 30 calendar days of the event	Date of death
Spouse or child death	Within 30 calendar days of the event	Date of death
Spouse — divorce	Within 30 calendar days of the event	Date of divorce
Dependent child Enters military service	Within 30 calendar days of the event	Date of event
Transfer to another subgroup/class or health insurance carrier	Within 30 calendar days of the event	Effective date of coverage through new subgroup/class or open enrollment effective date

Making other changes

Other changes

The ECOS form can also be used to enter a name change (for example, after a subscriber gets married) or an address change. It can be used to reinstate a member or to change a member's classification to COBRA.

Timing

Submit the ECOS form within 30 calendar days.

Using the ECOS form to make changes

ECOS form Complete page 6 (Change of Status) of the ECOS form to make changes to a subscriber's contract, including adding or deleting a member, changing an address or changing a member to COBRA classification.

Subscriber sections

The subscriber enters the following:

- Social Security Number, last name, first name, middle initial, marital status, gender and date of birth
- Home address beginning with street address, city, state and zip code
- County name for home address, country name (if other than USA)
- Primary and secondary phone number, indicating if these are home, work or cell phones
- All persons to be added or deleted (spouse, dependents), providing names, gender, date of birth, Social Security Number (required) and relationship code
 - N – Child (by Birth or Adoption)
 - S – Stepchild
 - P - Principal Support
 - A – Child Adoption in Process (court order required)
 - L – Legal Guardianship (court order required)
 - SD – Sponsored Dependent (documentation required)
 - C – Court order coverage (QMCSO) (court order required)
 - D – Disabled Child (PA 275) (physician statement required)
 - M – Medicare
- Permanent address of spouse or dependents if different from the subscriber
- Coordination of Benefits Information, indicating if the subscriber, spouse or dependent maintains other health care coverage

After entering the information, the subscriber must sign and date the form in the signature section.

Using the ECOS form make changes (continued)

Group information at the top of the form

The group enters the following at the top of the page:

- BCN group identification number
- Subgroup identification number
- BCN class identification number.

The group representative must sign and date the form in the signature section.

Group information after subscriber section

These boxes follow the “Coordination of Benefits Information.”

- Group name, employee Identification/badge/department number, if applicable
- Change desired and effective date of change
- Cancellation of subscriber, spouse or dependent and reason
- Loss of prior coverage, if applicable
- Medicare status, if applicable

Change of Status (ECOS Form, page 6)



Change of Status

BCBSM BCN Member (see instructions on Page 7)

BCBSM group	Division	BCN group number	Subgroup number	Class number	Employer representative signature	Date / /
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Subscriber Information *Required field

Subscriber Social Security number (*Required)	Subscriber last name*	Subscriber first name*	M.I.*	Marital status*	Gender
				<input type="checkbox"/> S <input type="checkbox"/> M	<input type="checkbox"/> M <input type="checkbox"/> F
New home street address*		City*	State*	ZIP code*	Email*
County*	Country—if other than USA*	New primary phone* <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell	New secondary phone* <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell		* Indicate changes only

List all persons to be added or deleted:							Relationship code (See instructions for codes)
Last name	First name	M.I.	Gender	Date of birth	Social Security number (Required)		
Spouse <input type="checkbox"/> Add <input type="checkbox"/> Delete			<input type="checkbox"/> M <input type="checkbox"/> F	/ /			
Dep. 1 <input type="checkbox"/> Add <input type="checkbox"/> Delete			<input type="checkbox"/> M <input type="checkbox"/> F	/ /			
Dep. 2 <input type="checkbox"/> Add <input type="checkbox"/> Delete			<input type="checkbox"/> M <input type="checkbox"/> F	/ /			
Dep. 3 <input type="checkbox"/> Add <input type="checkbox"/> Delete			<input type="checkbox"/> M <input type="checkbox"/> F	/ /			
Dep. 4 <input type="checkbox"/> Add <input type="checkbox"/> Delete			<input type="checkbox"/> M <input type="checkbox"/> F	/ /			

If the permanent address of the spouse or dependent is different from the address above, please complete the following information:	Spouse or Dependent (full name)	Home street address	City	State	ZIP code
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Coordination of benefits information

Do you, your spouse or dependents maintain other health coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, complete below: <input type="checkbox"/> Check here if this applies to all members on the contract.			
Person covered (full name)	Group name	Policy number	Carrier	Address

I have read and understand the conditions of this form, Subscriber signature: _____ Date: / /

Health savings and flexible spending account options

<input type="checkbox"/> FSAMED Effective date: / / Goal amount: _____ <input type="checkbox"/> HSA	Product indicator code <input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Cancel
<input type="checkbox"/> FSADEPCA Effective date: / / Goal amount: _____ <input type="checkbox"/> HSA opt out	

Employer/Group use only

Group name	Employee ID, badge or department #	Benefit code	Plan code
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Check reason for change below: <input type="checkbox"/> Marriage <input type="checkbox"/> Loss of eligibility (prior coverage) <input type="checkbox"/> Dependents <input type="checkbox"/> Name change <input type="checkbox"/> Open enrollment Date of event: / / Effective date: / /	Check type of cancellation and reason below. Type: <input type="checkbox"/> Contract <input type="checkbox"/> Spouse <input type="checkbox"/> Dependents Reason: <input type="checkbox"/> COBRA <input type="checkbox"/> Death <input type="checkbox"/> Left employment <input type="checkbox"/> Divorce <input type="checkbox"/> Dependent over age <input type="checkbox"/> Other <input type="checkbox"/> Retired <input type="checkbox"/> Other insurance Last date of coverage: / /
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Loss of eligibility (prior coverage)? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, complete below:			
Carrier's name (includes BCBSM or BCN)	Contract holder name	Policy #	Termination date / /

Are any listed members enrolled in Medicare? <input type="checkbox"/> No <input type="checkbox"/> Yes If Yes, check category <input type="checkbox"/> Over 65 and working <input type="checkbox"/> Retired <input type="checkbox"/> Disabled <input type="checkbox"/> ESRD
<input type="checkbox"/> Medicare primary per MSP laws Medicare A effective date: / / Medicare B effective date: / / Medicare D effective date: / / HIC #: _____

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Changing primary care physicians

Changing primary care physicians

Blue Care Network offers members these four ways to change their primary care physicians.

- Completing an Enrollment/Change of Status form
 - Online at **MiBCN.com**
 - Completing a Physician Selection form
 - Calling Customer Service
-

ECOS form

Members can select a new primary care physician by submitting an Enrollment/Change of Status form directly to BCN. Their new selection becomes effective two business days following the date of receipt of the form by BCN. See instructions that follow.

Note: The group representative does not need to sign the form.

Internet access

Members with Internet access can update their physician selection online, from the BCN home page at **MiBCN.com/find**. This feature offers several advantages:

- The change is made instantly.
 - Members can view and select from the most current provider information on file with BCN.
 - The site provides patient/provider matches based on member preferences, geography and the ages and gender of patients the doctor is accepting.
 - Members can register their reasons for changing doctors and be assured that this information will be carefully tracked.
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Physician Selection form

Members can select a new primary care physician by submitting a Physician Selection form to BCN. Please see section 1-5 of this manual for a copy of the form.

Contacting BCN Customer Service

Members can call BCN Customer Service at 1-800-662-6667. (Monday through Friday 8 a.m. to 5:30 p.m.) to update their physician selection. The new selection becomes effective two business days following the date of the call.

Using the ECOS form to change primary care physicians

ECOS form Complete page 4 (Change of Status) of the ECOS form to select or change a primary care physician.

Subscriber sections

The subscriber enters the following:

- Subscriber social security number, BCN group number, subgroup number and class number.
- Each member's last name, first name, physician's last name and first name, PCP number, physician's location and the reason for the PCP change. Indicate if the primary care physician has been seen in the last 12 months.
- The group/employer's name and the physician change effective date.

The subscriber must sign and date the form.

Primary Care Physician Selection Form (ECOS Form, page 3)



BCN Primary Care Physician Selection (see Page 5 for instruction)

Subscriber Social Security number (required for age 45 and older)	BCN group number	Subgroup number	Class number
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If you are enrolling in BCN, you need to select a primary care physician for you and each person on your contract. List your selection(s) on this form. You can choose a different primary care physician for each member of your family, or one to care for your entire family. If you elect to have one doctor for your entire family, you must select a family or general practice physician. You cannot choose a specialist as a PCP. You also need to fill out this form if you are already enrolled in BCN and have decided to change your PCP.

Need information about available primary care physicians?

Our website MiBCN.com/find provides the most current information on BCN-affiliated primary care physicians. You can search for a doctor by family practice, general medicine, internal medicine, internal medicine and pediatrics, pediatrics and preventive medicine, city or hospital group.

Member Information						
	Member's last name, first name	Physician last name, first name	Physician's NPI#	Physician address	If changing PCPs, list reason	Seen in the last 12 months?
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's name:				Date you changed to this physician:		
				/ /		
I have read and understand the conditions of this form. Subscriber signature:				Date:		
				/ /		

Return this form to start your health care partnership

We encourage you to return this form as soon as you enroll so we can notify your doctor of your membership.

Fax your completed form to 1-877-218-1466.

Or, mail to:

Membership and Billing

Mail Code C411

Blue Care Network

P.O. Box 5043

Southfield, MI 48086-5043

Changing your primary care physician is limited to once every 30 days. **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 when you change your primary care physician. If you change your primary care physician while you are being treated by a specialist, your new primary care physician must reauthorize the treatment you are receiving. Your treatment may not be covered until that occurs.

On an exception basis only, you may request to change your PCP effective immediately by calling the Physician Selection Line at 1-888-656-8276. TTY users call 1-800-257-9980.

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