500 Exchange Street, Providence, Rhode Island 02903-2699
(401) 459-1000 www.BCBSRI.com

Request for Change Of Participating Status For BlueCHiP for Medicare

The undersigned has signed a participation agreement with Blue Cross & Blue Shield of Rhode Island (BCBSRI), and has previously elected to not participate in the BlueCHiP for Medicare product, but now desires to reinstate participation for BlueCHiP for Medicare. As such, all of the terms of conditions of the Participation Agreement and the accompanying Administrative Policies will apply to any BlueCHiP for Medicare member you provide services to.

By signing below, you are acknowledging that you agree to become a participating Physician/Provider in BlueCHiP for Medicare, and are authorizing BCBSRI to make the necessary changes in our system.

Physician/Providers Name: _____
(Please print)

Physician/Provider
Or Authorized Agent
Signature: _____

Date: _____

Complete this form and fax or mail to us at the following address:

Fax Return:
Provider Database
Fax Number: 401-459-2099

Mail Return:
Blue Cross & Blue Shield of Rhode Island
500 Exchange Street
Providence, Rhode Island 02903-9961
Attn: Provider Database Unit