M Premier Care

Blue Care Network of Michigan

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

GradCare off-site registration form

For University of Michigan students enrolled in off-campus academic study or other off-site field placement.

Instructions

To obtain expanded coverage outside the GradCare network or affiliated providers (See your GradCare Member Handbook and Certificate of Coverage about details of your Plan), this completed form ***must*** be on file with BCN prior to the beginning of the academic off-campus study term. Please fax this form to BCN Claims at 877-232-3264, email to DocMgmtUL@bcbsm.com, or mail to: Blue Care Network, P.O. BOX 68710 Grand Rapids, MI 49516-8710.

Medical services with non-network providers must be pre-authorized by BCN as indicated in the GradCare Member handbook and Certificate of Coverage.

Eligible graduate student information

Name of eligible graduate student (Last, First, Middle Initial) _____ BCN Contract Number _____

Local address _____ City _____ State _____ Zip _____

Local phone number _____ E-mail address _____ Date of birth _____

Off-site address _____ City _____ State _____ Zip _____

Dependents (spouse, other qualified adult, children, etc) – complete if applicable

List dependents out of area during the off-site placement of the subscriber.

Name of eligible dependent (Last, First, Middle Initial) _____ Date of birth _____ Off-site Location _____

Name of eligible dependent (Last, First, Middle Initial) _____ Date of birth _____ Off-site Location _____

Name of eligible dependent (Last, First, Middle Initial) _____ Date of birth _____ Off-site Location _____

Name of eligible dependent (Last, First, Middle Initial) _____ Date of birth _____ Off-site Location _____

Off-site study area or field placement

Course name _____ Location _____

Specific program duration (begin/end) ___/___/___ – ___/___/___ Day phone number _____ Evening phone number _____

Brief program description _____

Department certification This section *must* be completed by your department.

Approved by (typed or printed) _____ Program name _____ Department phone _____

Department head or faculty advisor signature _____ Date signed _____

Subscriber certification and signature

The information above is correct to the best of my knowledge. I will immediately inform my Department Administrator of any changes in location, administrative approval, or other pertinent features of my off-site study/placement that may affect the extent of my health care coverage with GradCare.

Signature of eligible graduate student _____ Date signed _____