BLUE CROSS BLUE SHIELD OF MICHIGAN
TRINITY HEALTH - MERCYONE GENESIS
Network Deficiency Request

This form can be submitted by either the Colleague or the Provider.
Complete the information below to request a Network Deficiency Review.
Complete one form per member, per provider.
***Allow a minimum of 10 business days for a decision.**

Colleague or Subscriber Information

First and Last Name	Date of Birth
Home Address	
Home Phone	Work Phone
Email Address	Best time of Day to Call *(If Needed)*

Patient Information

Patient Name	Patient Date of Birth
Patient Phone (*if different from Colleague/Subscriber)*	

Reason for Request: Please briefly describe below the reason for the Network Deficiency Request.

Important Process Information

- You may be required to sign a release authorizing your provider to release your medical records to BCBSM.
- Medical records are required to review a network Deficiency request. Please include any available medical records (i.e., after visit summary) with this form.
- If additional information is needed, a member of our Clinical Team will contact the providers listed on this form.
- *Delay in receipt of complete medical records will result in a delayed decision.

Current / Local / Referring (Tier 1 or Tier 2 Physician) - Please Include Physician Name and Phone Number

Out of Network Facility Information

Facility Name	
Facility Contact Person (pertaining to your treatment)	Facility Contact Phone Number

Out of Network Physician Information

Physician Name	Physician Phone
Physician Address	

Name of person completing/submitting the form: _____

Patient Signature: _____ **Date:** _____

Submit the completed form to:

Blue Cross Blue Shield of Michigan
Email: networkdeficiencyrequest@bcbsm.com
Fax: 866-392-6608