BLUE CROSS AND BLUE SHIELD OF MINNESOTA

EMPLOYER PORTAL REQUEST FORM

Questions? Please call 1-877-293-7035 (group leaders) or 1-800-262-0821 (agents).

Please return completed form to EMPLOYER.PORTAL@BLUECROSSMN.COM (Please allow for up to 15 business days to process)

This form can be used to request access for multiple users within the same company.

*Indicates a required field to process.

CLIENT INFORMATION					
CLIENT ID:					
CLIENT LEGAL NAME*:					
DOING BUSINESS AS: (If different from legal name):					
ADDRESS*:					
CITY*:		STATE*:		ZIP*:	
AUTHORIZED SIGNER NAME*:		AUTHORIZED SIGNER PHONE*:			
AUTHORIZED SIGNER EMAIL*:					

AGENCY ACCESS AUTHORIZATION

Please note, the agent of record assigned to the Client, as well as certain agency staff will automatically be enrolled to have modify access for member enrollment, health analytics, census reporting and view billing of the Client unless Client designates differently below.
If you **DO NOT** want your agent to have this access, please indicate below by checking the box.

I **do not** authorize my agent to have access to the following company data:

- ☐ BILLING
- ☐ MEMBER ENROLLMENT
- ☐ CENSUS REPORT
- ☐ HEALTH ANALYTICS

☐ If you **DO NOT** want agency staff to have access.

AGREEMENT (PLEASE READ CAREFULLY BEFORE SIGNING)

I attest I am an authorized signer for the Client listed above. By signing this form, on behalf of the Client listed above, Client understands and agrees to the following terms and will notify any assigned user of all terms stated below.

1. Client agrees to ensure designated user(s) will not share user id and/ or password with anyone.
2. Client agrees to ensure the designated user(s) will only use Blue Cross and Blue Shield of Minnesota (Blue Cross) Portals, as directed within their job function, and only to the extent expressly authorized by Blue Cross.
3. Client agrees to ensure no sharing of any information obtained through any Blue Cross Portal, with anyone unless required.
4. Client understands it will be held accountable for all actions performed within any Blue Cross Portal, under any associated authorized user id and password.
5. If this form is completed as an electronic form, both parties agree to conduct this transaction electronically.
6. The Client listed above, hereby designates as its authorized representative to directly receive Protected Health Information (PHI) from Blue Cross. The Client and any authorized user(s) are responsible for complying with the requirements of all applicable state and federal privacy laws, including but not limited to HIPPA.
7. Client shall immediately notify Blue Cross if user is no longer allowed access through any Blue Cross Portal or PHI access.

SIGNATURE	
Electronic Signature*: (Authorized Signer):	Date*:

PLEASE PROCEED TO THE NEXT PAGE TO ASSIGN THE USERS(S)ACCESS

(01/21)

1. INDIVIDUAL USER INFORMATION					
TYPE OF ACCESS:	Select	ROLE:	Select		
DO YOU HAVE AN EMPLOYER PORTAL ID: ☐ YES ☐ NO		IF YES, PLEASE PROVIDE:			
FIRST & LAST NAME:*					
COMPANY NAME*:		JOB TITLE:			
ADDRESS*:					
CITY*:		STATE*:		ZIP CODE*:	
PHONE*:		EMAIL*:			

MEMBER ENROLLMENT ACCESS (IF YOU CURRENTLY SUBMIT ENROLLMENT ELECTRONICALLY ON AN ONGOING BASIS, PLEASE SELECT VIEW ONLY ACCESS)		
ACCESS TYPE TO ENROLLMENT:	Select	(If dental access is needed, elect Modify. View only access is not available for dental).
ACCESS TO ALL GROUPS:	Select	(Not available if COBRA groups are administered by a TPA)
IF NO, ACCESS THESE GROUP #S		

EMPLOYER REPORTING (HEALTH ANALYTICS AVAILABLE ONLY FOR CLIENTS WITH 50+ MEMBERS)
ACCESS TO EMPLYER REPORTING: ☐
You will access Blue Cross Health Analytics through a separate portal called Connect. You will receive a separate email with login credentials/information.

CENSUS REPORTS
ACCESS TO CENSUS REPORTS: ☐

E-BILL ACCESS			
ACCESS TO BILLING INVOICES:	Select	PHI ACCESS (Self Insured Client Only):	☐
ACCESS TO ALL BILLING INVOICES:	Select	IF NO, ACCESS THESE ACCOUNTS #S	

2. INDIVIDUAL USER INFORMATION					
TYPE OF ACCESS:	Select	ROLE:	Select		
DO YOU HAVE AN EMPLOYER PORTAL ID: ☐ YES ☐ NO		IF YES, PLEASE PROVIDE:			
FIRST & LAST NAME:*					
COMPANY NAME*:		JOB TITLE:			
ADDRESS*:					
CITY*:		STATE*:		ZIP CODE*:	
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COMPANY NAME*:		JOB TITLE:			
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