

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
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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