

Web Enrollment 2021 & Resent Submissions

Greater Tompkins Consortium
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A nonprofit independent licensee of the Blue Cross Blue Shield Association

Web Enrollment Tips



A nonprofit independent licensee of the Blue Cross Blue Shield Association



AGENDA

Using this presentation as a resource, you will learn how to:

- Use Forgot Your Username slide 4
- Use Forgot Your Password slide 6
- Add/Activate or Remove a Group Number slide 9
- Member Roster and Eligibility features slide 10
- Add a Family Member slide 14
- Change Coverage slide 24
- Cancellation Reason slide 32
- Reinstate Policies slide 33
- Enroll a New Member slide 34
- Recent Submissions slide 43
- Contact Us - Use Self Service Features slide 49
 - *(Name Change, SSN and Date of Birth updates)*
- FAQs slide 52

Forgot Your Username or Password

▲ We're Here for you: Stay informed about the [coronavirus \(COVID -19\)](#)

Employer Login

Username

Password

Log In

Forgot Your Username?
Forgot Your Password?

Create an Account

- Employee Administration
- Order ID Cards
 - View Member Roster
 - Update Member Policy
- Group Administration
- Pay Your Bill
 - Compare New Plan Rates and Benefits

Register & Create an Account

Forgot Your Username

Forgot Username

Call the Web Help Desk
1 (800) 278 - 1247

 **We're sorry, we cannot process your request online.**

Please call our Web Security Help Desk for assistance: 1-800-278-1247

Forgot Your Password

Forgot Password

Step 1: Please complete the following fields

** Required Fields*

Username: *	<input type="text"/>
First Name: *	<input type="text"/>
Last Name: *	<input type="text"/>

Back

Continue

Questions? Contact our Web Help Desk for assistance at 1-800-278-1247.

Forgot Your Password

Forgot Password

Step 2: Please provide the correct answer to your secret question

*** Required Fields**

Your Security Question is: Childhood hero?

Security Answer:*

Back

Continue

Questions? Contact our Web Help Desk for assistance at 1-800-278-1247.

Forgot Your Password

Employers > Forgot Password

Your password hint will be displayed.
Call the Web Help Desk if the hint doesn't help.
1 (800) 278 - 1247

Forgot Password

 Your Request Was Successful

Step 3: Login to your account.

*** Required Fields**

Your password hint is:

t21

If this password hint doesn't help, contact our Web Help Desk for assistance at 1-800-278-1247.

Username: *

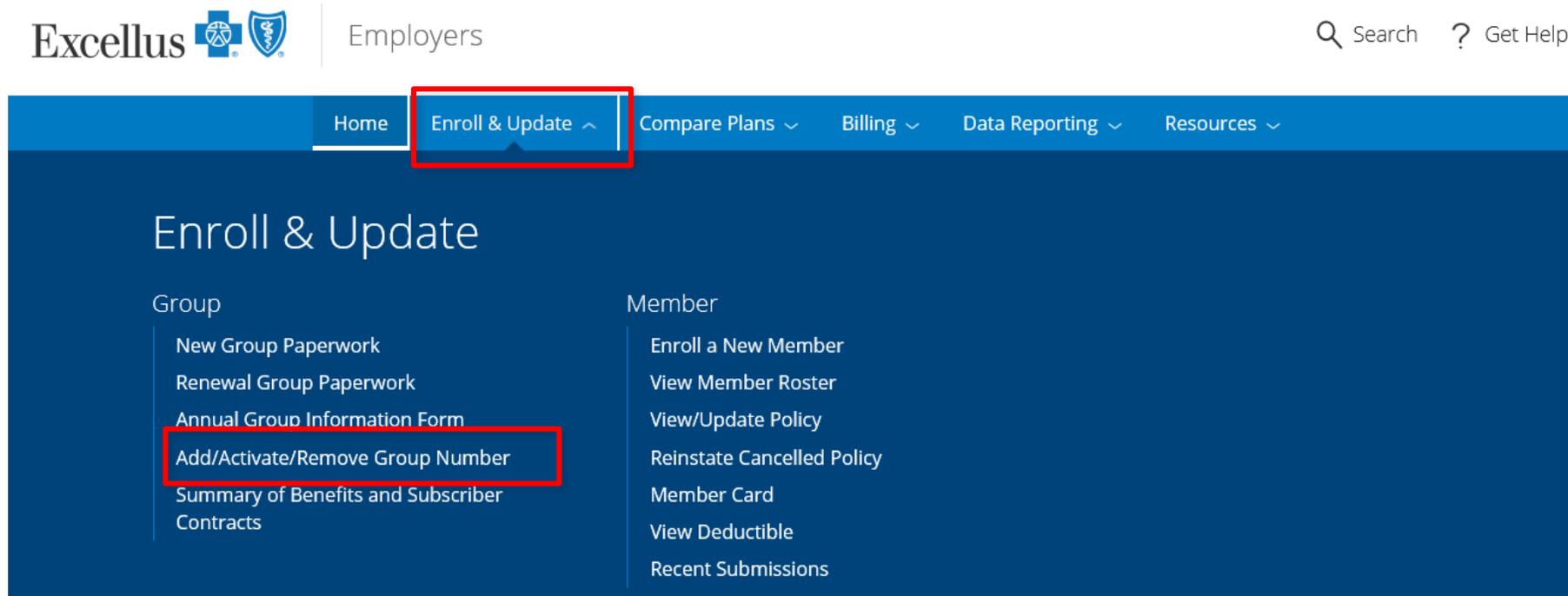
carlteam

Password: *

Cancel

Log In

Add/Activate, or Remove a Group Number



The screenshot shows the Excellus Employers portal. At the top left is the Excellus logo and the word 'Employers'. To the right are search and help icons. A blue navigation bar contains 'Home', 'Enroll & Update', 'Compare Plans', 'Billing', 'Data Reporting', and 'Resources'. The 'Enroll & Update' menu is expanded, showing two columns: 'Group' and 'Member'. The 'Group' column includes 'New Group Paperwork', 'Renewal Group Paperwork', 'Annual Group Information Form', 'Add/Activate/Remove Group Number', 'Summary of Benefits and Subscriber Contracts', and 'Contracts'. The 'Member' column includes 'Enroll a New Member', 'View Member Roster', 'View/Update Policy', 'Reinstate Cancelled Policy', 'Member Card', 'View Deductible', and 'Recent Submissions'. The 'Add/Activate/Remove Group Number' option is highlighted with a red box.

- Keep your Group Numbers up to date by Adding and Activating any newly added Group Numbers or Removing any old Group Numbers
- Once you Add a Group Number and get notification it is added make sure to go back and Activate that Group Number to process transactions

Member Roster & Eligibility Features



View Member Roster

- View a list of Active, Terminated, and Pending subscribers.
- Hold the CTRL Key to select multiple groups.
- Verify enrollment statuses.

View Member Roster

For multiple group numbers, hold CTRL key to select.

0011122200
0011123230
0011123211
0011142421
0011152521

Search Reset

Employee Status

- Active
- Terminated
- Pending
- All

Choose your Member

View Member Roster

For multiple group numbers, hold CTRL key to select.

- Employee Status
- Active
 - Terminated
 - Pending
 - All

Download Results into Excel

GROUP NUMBER :

PACKAGES	CLASS ID	PACKAGE ID	EFFECTIVE DATE	TERMINATION DATE
Excellus BCBS EPO 0/0/0	0001	MXBN0017	01/01/2019	12/31/9999
Excellus BCBS EPO 0/0/0	0001	MXBN0022	01/01/2019	12/31/9999
CNY Preferred Gold 0/0/0 1500/3000	0001	MXIN0001	01/01/2015	12/31/2015

Find a Subscriber (Last name required).

First Name Last Name

Search by name or scroll through the list of members

SUBSCRIBER NAME	MEMBER ID	DATE OF BIRTH	GENDER	PACKAGE ID	CONTRACT TYPE	STATUS	DEPT CODE	EMP NUM	PAY LOCATION
Subscriber Name	Subscriber ID	Subscriber DOB		MXBD0005	Subscriber	Active			
				MXBB0004	Subscriber	Active			
				MXBD0011	Subscriber and Spouse	Active			

Choose your transaction

View/Update Policy

[Return to Roster](#)

SUBSCRIBER INFORMATION: **Subscriber Name**

Address: **Subscriber Address**

Phone: **Subscriber Phone Number**

Date Of Birth: **Subscriber Date of Birth**

Gender: Male

Member ID: **000000000**

POLICY INFORMATION

Plan Name: **Excellus BCBS EPO Hybrid**

Status: **ACTIVE**

Effective Date/ Term Date: 04/01/2018 -

Group Name: **Excellus NY Benefit On Exchange Individual**

Group Number: **00000000X000**

Enrollment Type:

Employee Number:

Contract Type: Subscriber

Class Id: 0000

Dependent Covered TO: 26 YEARS

Student Covered To: 26 YEARS

FAMILY MEMBER INFORMATION

Family Member Details

MEMBER NAME	MEMBER SUFFIX	STATUS	BIRTH DATE	AGE	RELATIONSHIP	GENDER	CURRENT PCP	ALT PCP
	00	Active			Subscriber	Male		

Update Subscriber Information

[Change Address/Phone Number](#)

[Request Member Card](#)

Update Policy Information

[Change Coverage](#)

[Cancel Coverage](#)

[Ask a Membership Question](#)

Add or Remove a Family Member

[Add a Family Member](#)

[Remove a Family Member](#)

Add a Family Member



View/Update Policy

[Return to Roster](#)

SUBSCRIBER INFORMATION: Subscriber Name

Address: **Subscriber Address** [Change Address/Phone Number](#)

Phone: **Subscriber Phone Number**

Date Of Birth: **Subscriber Date of Birth** [Request Member Card](#)

Gender: Male

Member ID: **000000000**

POLICY INFORMATION

Plan Name: **Excellus BCBS EPO Hybrid** [Change Coverage](#)

Status: **ACTIVE** [Cancel Coverage](#)

Effective Date/ Term Date: 04/01/2018 -

Group Name: **Excellus NY Benefit On Exchange Individual** [Ask a Membership Question](#)

Group Number: **00000000X000**

Enrollment Type:

Employee Number:

Contract Type: Subscriber

Class Id: 0000

Dependent Covered TO: 26 YEARS

Student Covered To: 26 YEARS

FAMILY MEMBER INFORMATION

MEMBER NAME	MEMBER SUFFIX	STATUS	BIRTH DATE	AGE	RELATIONSHIP	GENDER	CURRENT PCP	ALT PCP
	00	Active			Subscriber	Male		

Add a Family Member

[Add a Family Member](#)

[Remove a Family Member](#)

Name Change
Update SSN
Questions

Anything starred in red is required

Excellus  Home Enroll & Update Compare Plans Billing Data Reporting Resources

Please Note: Follow this link to change/cancel coverage for a Medicare Advantage or Medicare Supplemental member. View Medicare Enrollment Forms.

Add a Dependent

* Required Fields

Follow this link to [Reinstate a Canceled Policy](#) within 30 days of termination

Subscriber Name: John Doe Subscriber ID: 111X00011

Group & Subscriber Information

Group/Employer Information

Qualifying Event Date: * MM-DD-YYYY 

Desired Effective Date: * MM-DD-YYYY 

Employee Status: * Active 

Employee Number:

Department Number:

[Continue >](#)

Group & Subscriber Information

Group/Employer Information

Qualifying Event Date: *  MM-DD-YYYY  Please Select

Desired Effective Date: *  MM-DD-YYYY  Please Select

Employee Status: * Active 

Employee Number: 12472716

Department Number:

[Continue >](#)  Please fix the errors above before continuing.

When adding a Family Member use **Qualifying Event Date**

- Date of Birth
- File Date Of Divorce
- Date of Marriage
- Date of Adoption

Desired Effective Date cannot be before Qualifying Event Date

Family Member Information

Plan Update

Add a Dependent

* Required Fields

Follow this link to [Reinstate a Canceled Policy](#) within 30 days of termination

Subscriber Name: **Subscriber Name**

Subscriber ID: **00000000**

Group & Subscriber Information

Family Member Information

To add a new dependent, click the 'Add a Family Member' button below.

Add a Family Member

← Back

Continue ►

Legal Statements

Enter Family Member Information

Family Member Information

Family Member

Relationship to Subscriber: *

First Name: *

Last Name: *

Title:

Gender: * Male Female

Date of Birth: *

Social Security Number:

We are required to ask for the Social Security number for members greater than one year old in order to meet our reporting obligations under the Affordable Care Act.

Select Coverage: Excellus BCBS EPO Hybrid 25/40/150 600/1200

Make sure to Select Coverage or dependent will not be added

- Select -
- Spouse
- Domestic Partner
- Dependent (Child, Stepchild)
- Dependent Student (19 or older)
- Handicapped Dependent

- When adding a *Dependent Student*, the students age should be 19-26
- When selecting a *Handicapped Dependent* the dependent should be **OVER 26** years old

Make changes or Continue

Plan Update

Add a Dependent

* Required Fields

Follow this link to [Reinstate a Canceled Policy](#) within 30 days of termination

Subscriber Name: **Subscriber Name** Subscriber ID: **00000000**

Group & Subscriber Information

Family Member Information

Name	Relationship	Date of Birth	Select Coverage	
Dependent Name	Spouse	01/01/20XX	<input checked="" type="checkbox"/> Excellus BCBS EPO Hybrid 25/40/150 600/1200	Edit Delete

To add a new dependent, click the 'Add a Family Member' button below.

[Add a Family Member](#)

Add an additional Family Member or Continue

[← Back](#)

[Continue ▶](#)

Medicare Information

Other Coverage Information

Legal Statements

Medicare Information

Add a Dependent

* Required Fields

[Follow this link to Reinstate a Canceled Policy within 30 days of termination](#)

Subscriber Name: **Subscriber Name** Subscriber ID: **00000000**

Group & Subscriber Information

Family Member Information

Medicare Information

Medicare Eligibility

Do any of the new dependents have Medicare coverage? * Yes No

Other Coverage Information

Legal Statements

Medicare Information

Medicare Eligibility

Do any of the new dependents have Medicare coverage? * Yes No

Which members currently have Medicare coverage? * **Dependent Name (01/01/20XX)**

Lisa's Medicare Coverage Information

Reason for Medicare Eligibility: *

Health Insurance Claim Number: *

Effective Date - Medicare A:

Effective Date - Medicare B:

You are required to fill in at least one of the above Effective Dates.

If **Yes** is selected Medicare Information box pops up

Other Coverage

Other Coverage Information

Other Coverage

Have any of the new dependents had coverage under another health or dental insurance carrier during the last 63 days? *

Yes No

[← Back](#) [Continue ▶](#)

If **Yes** is selected Other Coverage Information box pops up

Other Coverage Information

Other Coverage

Have any of the new dependents had coverage under another health or dental insurance carrier during the last 63 days? *

Yes No

Which members have or had other coverage? *

Dependent Name (01/01/20XX)

Lisa's Other Insurance Information

Other Carrier Name: * [Search](#)

Are you keeping this other insurance? * Yes No

If no, what is the cancellation date? * MM-DD-YYYY

Effective Date of Other Insurance: * MM-DD-YYYY

Policy Holder's First Name: *

Policy Holder's Last Name: *

Policy Holder's Insurance Number: *

Type of Coverage: *

Persons Covered: *

Relationship to Subscriber: *

- Other Coverage Information if coordinating benefits with another carrier
- You can type in the *Other Carrier Name* first select *Search* then cancel out of the Carrier Name Search box

Legal Statements

Legal Statements

Please check the statements below on behalf of the subscriber, and keep a copy of the signed application for your records.

Subscriber Acceptance

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed \$5,000 and the stated value of the claim for each such violation. I have thoroughly read, understand and agree to comply with the terms of the Release.

I Agree *

Medical Release Acceptance

I authorize Excellus BlueCross BlueShield to request and receive medical or dental information regarding me or my covered dependents from my healthcare practitioner or healthcare institution either orally or in writing and to use this information for providing coverage. Providing coverage includes: processing claims, reviewing grievances or complaints involving care; and quality assurance reviews of care, whether based on a specific complaint or a routine audit of randomly selected cases. In the use of data for these purposes, we may transmit personal information to third parties with whom we contract, including pharmacy benefit managers, disease management vendors or surveyors. I have thoroughly read, understand and agree to comply with the terms of the Release.

I Agree *

[← Back](#) [Submit →](#)

Add a Dependent Summary

Plan Update

[« Return to Entry Screen](#)

To finalize enrollment, review and click 'Submit.' Use the 'Edit' links below to make any corrections.

Subscriber Name: **Subscriber Name** Subscriber ID: **00000000**

Group/Employer Information [Edit](#)

Employee Number: Department Number:
Employee Status: **Active** Qualifying Event Date: **06-26-2019**
Desired Effective Date: **07-01-2019**

Subscriber Information

First Name: **Subscriber First Name**
Last Name: **Subscriber Last Name**
Gender:

Address Information

Street Address: **Subscriber Street Address**
City:
State/Province: **New York**
Zip/Postal Code:

Family Member Information

Spouse [Delete](#) [Edit](#)

First Name: **Dependent First Name** Title:
Last Name: **Dependent Last Name**
Relationship to Subscriber: **Spouse**
Gender: **Female** Social Security Number:
Date of Birth:

[Add a Family Member](#) **Add an additional Family Member**

Persons Covered: **Excellus BCBS EPO Hybrid 25/40/150 600/1200**

Dependent Name 

Medicare Information [Edit](#)

Do you or your family members have Medicare coverage? **No**

Other Coverage Information [Edit](#)

Have you or any of your family members had coverage under another health or dental insurance carrier during the last 63 days? **No**

If everything is correct, please click 'Submit'. To make any changes, use the 'Edit' links above. [Submit](#)

• Make sure that the Dependents were included
• Green Check Mark

Add a Dependent Confirmation

Plan Update

Add a Dependent Confirmation

Submission Receipt

✔ Thank You! Your application for **Subscriber Name** was received. Depending on any additional enrollment requirements, your transaction will be processed within 3 to 5 business days.

Your confirmation number is: 2019-06-20 15:11:20.549114

Subscriber ID(s): 000000000

⚠ Please print or save this receipt and keep a copy of the signed application for your records.

 [Print Enrollment Form](#)  [Save Enrollment Form as PDF](#)

Print Enrollment Form, Save as PDF or use Resent Submissions and you're complete! Allow 3 – 5 business days

Change Coverage

View/Update Policy

[Return to Roster](#)

SUBSCRIBER INFORMATION: **Subscriber Name**

Address **Subscriber Address** [Change Address/Phone Number](#)

Phone **Subscriber Phone Number** [Request Member Card](#)

Date Of Birth **Subscriber Date of Birth**

Gender **Male**

Member ID **000000000**

POLICY INFORMATION

Plan Name **Excellus BCBS EPO Hybrid**

Status **ACTIVE**

Effective Date/ Term Date **04/01/2018 -**

Group Name **Excellus NY Benefit On Exchange Individual**

Group Number **0000000X000**

Enrollment Type

Employee Number

Contract Type **Subscriber**

Class Id **0000**

Dependent Covered TO **26 YEARS**

Student Covered To **26 YEARS**

FAMILY MEMBER INFORMATION

MEMBER NAME	MEMBER SUFFIX	STATUS	BIRTH DATE	AGE	RELATIONSHIP	GENDER	CURRENT PCP	ALT PCP
	00	Active			Subscriber	Male		

[Change Coverage](#)

[Cancel Coverage](#)

[Ask a Membership Question](#)

[Add a Family Member](#)

[Remove a Family Member](#)

- Submit 1 Change Coverage enrollment For Medical, Dental and RX policy changes
- Submit 2 separate Change Coverage enrollments for Dental & Medical When different Effective Dates

Change Coverage



Change Coverage

* Required Fields

[Follow this link to Reinstate a Canceled Policy](#) within 30 days of termination

Subscriber Name: **Subscriber Name** Subscriber ID: **00000000**

Group & Subscriber Information

Group/Employer Information

Desired Effective Date: *

Employee Status: *

Employee Number:

Department Number:

Subscriber Information

First Name: *

Last Name: *

Title:

Gender:

Date of Birth: *

Subscriber ID: **00000000**

Address Information

Is the address in 'Care Of?'

Street Address: *

City: *

Country: *

State/Province: *

Zip/Postal Code: *

Daytime Phone Number:

Email Address:

Select Coverage



Change Coverage

* Required Fields

[Follow this link to Reinstatement a Canceled Policy](#) within 30 days of termination

Subscriber Name: **Subscriber Name** Subscriber ID: **00000000**

Group & Subscriber Information

Select Coverage

Select Medical Plan

Current Medical Policy for Subscriber ID: 200370880

Medical Group Number:	Class:	Enrollment Code:	Package-Product Name:
00000000X000	All Actives	DAG	Excellus Blue PPO Signature Deductible 3 1350/2700

Would you like to change/add your Medical coverage? Yes

Medical Group Number: *

Medical Class: *

Medical Enrollment Code: *

Select Dental Plan

Would you like to change/add your Dental coverage? Yes

Family Member Information

Medicare Information

Other Coverage Information

Legal Statements

- Select Yes to change or add coverage
- Select: new Medical Group Number, Medical Class and Enrollment Code.
- Select Yes to add or change Dental coverage

Family Member Information

Change Coverage

* Required Fields

Follow this link to [Reinstate a Canceled Policy](#) within 30 days of termination

Subscriber Name: **Subscriber Name**

Subscriber ID: **00000000**

Group & Subscriber Information

Select Coverage

Family Member Information

To enroll members, check the policy(ies) for each family member. Use 'Edit' links to update dependent profile information.

Name	Relationship	Date of Birth	Select Coverage	
Spouse Name	Spouse		<input checked="" type="checkbox"/> EPO HDHP 6000/12000 6000/12000	Edit
Dependent Name	Dependent (Child, Stepchild)		<input type="checkbox"/> EPO HDHP 6000/12000 6000/12000	Edit

[Add a Family Member](#)

[← Back](#)

[Continue ►](#)

Medicare Information

Other Coverage Information

Legal Statements

- Must select coverage
- For all dependents

If coverage is not selected dependents will lose coverage with change

Medicare, Other Coverage Information, and Legal Statements



Medicare Information

Medicare Eligibility

Do you or your family members have Medicare coverage? * Yes No



Other Coverage Information

Other Coverage

Have you or any of your family members had coverage under another health or dental insurance carrier during the last 63 days? * Yes No



Legal Statements

Please check the statements below on behalf of the subscriber, and keep a copy of the signed application for your records.

Subscriber Acceptance

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed \$5,000 and the stated value of the claim for each such violation. I have thoroughly read, understand and agree to comply with the terms of the Release.

I Agree *

Medical Release Acceptance

I authorize Excellus BlueCross BlueShield to request and receive medical or dental information regarding me or my covered dependents from my healthcare practitioner or healthcare institution either orally or in writing and to use this information for providing coverage. Providing coverage includes: processing claims, reviewing grievances or complaints involving care; and quality assurance reviews of care, whether based on a specific complaint or a routine audit of randomly selected cases. In the use of data for these purposes, we may transmit personal information to third parties with whom we contract, including pharmacy benefit managers, disease management vendors or surveyors. I have thoroughly read, understand and agree to comply with the terms of the Release.

I Agree *

Change Coverage Summary

Plan Update

[Return to Entry Screen](#)

To finalize enrollment, review and click 'Submit.' Use the 'Edit' links below to make any corrections.

Subscriber Name: **Subscriber Name** Subscriber ID: **00000000**

Group/Employer Information [Edit](#)

Employee Number: Department Number:
Employee Status: Desired Effective Date: **08-01-2019**

Subscriber Information [Edit](#)

First Name: **First Name**
Last Name: **Last Name**
Gender: **Male**
Date of Birth: **04-01-1981**

Address Information

Street Address: **123 Street Address**
City: **City**
State/Province: **New York**
Zip/Postal Code: **Zipcode**

Select Coverage

Medical Group Number: **00000000X000**
Medical Enrollment Code: **DAG**

Family Member Information [Edit](#)

Spouse

First Name: **First Name** Title:
Last Name: **Last Name**
Relationship to Subscriber: **Spouse**
Gender: **Female** Social Security Number:
Subscriber ID: **00000000** Date of Birth: **01/01/20XX**

[Add a Family Member](#)

Persons Covered: **Excellus Blue PPO Signature Deductible 3 1350/2700**

Subscriber	<input checked="" type="checkbox"/>
Spouse	<input checked="" type="checkbox"/>

Medicare Information [Edit](#)

Do you or your family members have Medicare coverage? **No**

Other Coverage Information [Edit](#)

Have you or any of your family members had **No** coverage under another health or dental insurance carrier during the last 63 days?

If everything is correct, please click 'Submit'. To make any changes, use the 'Edit' links above. [Submit](#)

• Make sure that the Dependents were included Green Check Mark

Final Proof and Edit step

- Verify all information is accurate
- Scroll down and verify all dependents have Coverage
- Must display Green Check

Family Member Information			
Spouse			
First Name:		Title:	
Last Name:			
Relationship to Subscriber:	Spouse		
Gender:	Male	Social Security Number:	
Date of Birth:	04-03-1991		

Persons Covered:	Dental Plan
Jaron Davie	<input checked="" type="checkbox"/>

Change Coverage Confirmation

Plan Update

Change Coverage Confirmation

Submission Receipt



✔ Thank You! Your application for **Subscriber Name** was received. Depending on any additional enrollment requirements, your transaction will be processed within 3 to 5 business days.

Your confirmation number is: 2019-07-05 15:15:14.335081

Subscriber ID(s): 000000000

⚠ Please print or save this receipt and keep a copy of the signed application for your records.

 [Print Enrollment Form](#)

 [Save Enrollment Form as PDF](#)

Reason for Cancellation & Desired Cancellation Date



Cancel Coverage

Only active policies are displayed below. By canceling a policy, you are also canceling coverage for all family members on the policy.

Subscriber: **Subscriber Name** ID: **00000000**

Coverage Information

Select Policy(ies) to Cancel: * Excellus BluePPO Copay Deductible Plan 25/40/150 500/1000

Reason for Cancellation: * **- Select -**

Desired Cancellation Date: * **MM-DD-YYYY**

Continue

Desired Cancellation Date must be the last day of the month

- Select -
- Left Employment
- Employee No Longer Wants Coverage
- Deceased
- Subgroup Transfer
- Change in Employee Eligibility Status
- Medicare Eligible
- Enrolled in Error
- Benefits Terminated - Pandemic

Use the accurate reason for cancellation

Reinstate Policy

Reinstate Cancelled Policy

Follow the steps below to request that a subscriber's cancelled or terminated policy be made active again.

Step 1: Lookup the subscriber's cancelled policy using [View/Update Policy](#).

Step 2: On the View/Update Policy page, under the Policy Information section, select the Reinstate Terminated Policy button.

NOTE: A policy can only be reinstated within 30 days of termination, so if there is no Reinstate Terminated Policy button, you will need to re-enroll the member in a new policy.

Example - Policy information with Reinstate Terminated Policy button

POLICY INFORMATION

TERMED POLICIES

Plan Name	SUBBlue
Status	❌ TERMED
Effective Date/ Term Date	01/01/2018 - 02/08/2019
Group Name	Example Group
Group Number	00#####-0001
Employee Number	#####

Change Coverage

Cancel Coverage

Reinstate Terminated Policy

- **The policy must be in a cancelled status for the Reinstate button to display.**
- **Can go back to the 1st of the previous 30 days.**
- **Will receive an edit message if try to go back farther**
- **Submit to Enrollment & Billing Support – slide 49 when Over the previous 30 days.**

Step 3: Complete the contact section of the electronic form and click "Submit"

Enroll a New Member



Enroll New Member



Excellus Employers Search Get Help

Home **Enroll & Update** Compare Plans Billing Data Reporting Resources

Enroll & Update

- Group**
 - New Group Paperwork
 - Renewal Group Paperwork
 - Annual Group Information Form
 - Add/Activate/Remove Group Number
 - Summary of Benefits and Subscriber Contracts
- Member**
 - Enroll a New Member**
 - View Member Roster
 - View/Update Policy
 - Reinstate Cancelled Policy
 - Member Card
 - View Deductible

Enroll New Member

Enroll new members.

View Member Roster

View a list of active, terminated, and pending subscribers.

View/Update Policy

Make changes to, look up subscribers, and update policies.

Reinstate Member

Reinstate previously inactive Members.

Member Card

Print, update, and order new Member Cards.

Enroll and Billing Support

Find out how to access guidance on enrollment & billing issues.

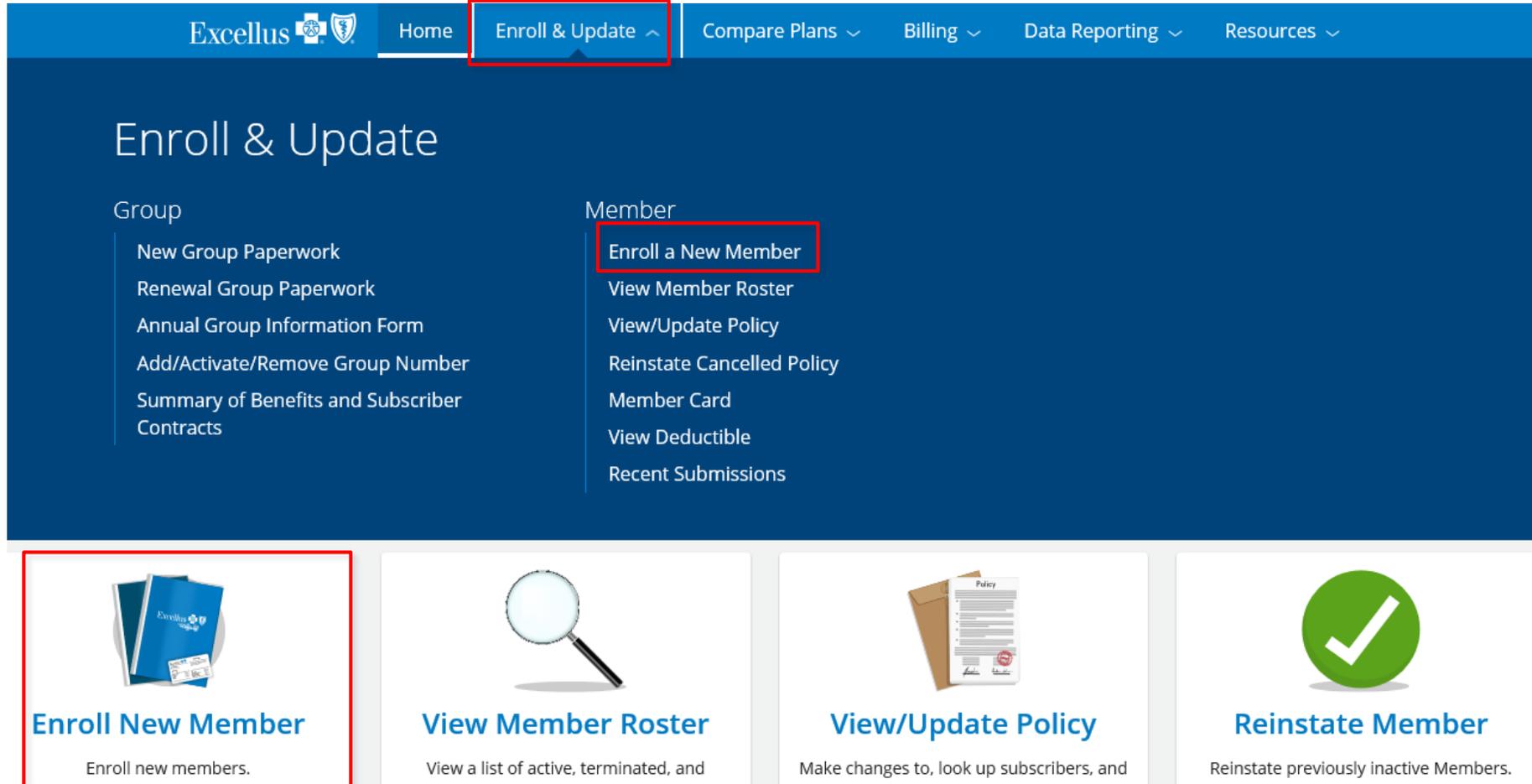
Forms

View and print copies of our most frequently used forms.

Contact Us

Questions? Find ways to contact us through email, telephone and in person.

Enroll New Member



Excellus  Home **Enroll & Update**  Compare Plans  Billing  Data Reporting  Resources 

Enroll & Update

Group

- New Group Paperwork
- Renewal Group Paperwork
- Annual Group Information Form
- Add/Activate/Remove Group Number
- Summary of Benefits and Subscriber Contracts

Member

- Enroll a New Member**
- View Member Roster
- View/Update Policy
- Reinstate Cancelled Policy
- Member Card
- View Deductible
- Recent Submissions



Enroll New Member

Enroll new members.



View Member Roster

View a list of active, terminated, and



View/Update Policy

Make changes to, look up subscribers, and



Reinstate Member

Reinstate previously inactive Members.

Anything starred in red is required

Enroll a New Member

* Required Fields

Follow this link to [Reinstate a Canceled Policy](#) within 30 days of termination

Group & Subscriber Information

Group/Employer Information

Reason for Enrollment: * New Hire

Hire Date: * 06-01-2019

Desired Effective Date: * 07-01-2019

Employee Status: * Active

Employee Number:

Address Information

Is the address in 'Care Of?'

• Submit 2 separate Change Coverage enrollments for Dental & Medical when different Start dates.

Enroll a New Member

Please Note: Follow this link to [Enroll a new Medicare Advantage or Medicare Supplemental member](#). View [Medicare Enrollment Forms](#).

* Required Fields

Follow this link to [Reinstate a Canceled Policy](#) within 30 days of termination

Group & Subscriber Information

Group/Employer Information

Reason for Enrollment: * - Select -

Desired Effective Date: * MM-DD-YYYY

Employee Status: * - Select -

Employee Number:

Department Number:

Enroll a New Member

Group & Subscriber Information

Group/Employer Information

Reason for Enrollment: *

Hire Date: *

Desired Effective Date: *

Employee Status: *

Employee Number:

Department Number:

New Hire

MM-DD-YYYY

MM-DD-YYYY

Active

- Select Reason for Enrollment
 - New Hire
- Enter the Hire date
- Enter the effective date, it can be after Hire date
- It is up to the employer if there is a waiting period before employer coverage beings.

Select Coverage

* Required Fields

[Follow this link to Reinstate a Canceled Policy within 30 days of termination](#)

Group & Subscriber Information

Select Coverage

Select Medical Plan

Decline or Keep Existing Plan:

Select Dental Plan

Decline or Keep Existing Plan:

Dental Group Number: *

- Select -

◀ Back

Continue ▶

- Select Decline when you don't want to make any changes to the Plan. It will not terminate Coverage. Retains the same coverage
- Leave unselected to select coverage
- Select: Medical Group Number, Class, Enrollment Code.
- Continue for Dental and Pharmacy when applies

Add a Family Member

Family Member Information

To enroll family members, click the 'Add a Family Member' button below. Otherwise click 'Continue'.

Add a Family Member

[Back](#) [Continue](#)

Family Member Information

Family Member

Relationship to Subscriber: *

First Name: *

Last Name: *

Title:

Gender: * Male Female

Date of Birth: *

Social Security Number:

We are required to ask for the Social Security number for members greater than one year old in order to meet our reporting obligations under the Affordable Care Act.

Select Coverage: SimplyBlue Plus PPO Copay 15/25/150

[Save](#) [Cancel](#)

- Select -

- Spouse
- Domestic Partner
- Dependent (Child, Stepchild)
- Dependent Student (19 or older)
- Handicapped Dependent

Enroll a New Member Summary

Enroll a New Member

[« Return to Entry Screen](#)

To finalize enrollment, review and click 'Submit.' Use the 'Edit' links below to make any corrections.

Group/Employer Information		Edit
Employee Number:		Department Number:
Employee Status: Active		Hire Date: 07-01-2019
Desired Effective Date: 08-01-2019		

Subscriber Information		Edit
First Name:	First Name	Family Member Information To enroll family members, click the 'Add a Family Member' button below. Otherwise click 'Continue'. <input type="button" value="Add a Family Member"/> Add an additional Family Member
Last Name:	Last Name	
Gender:	Female	
Date of Birth:		

Address Information		Persons Covered: SimplyBlue Plus PPO Copay 15/25/150
Street Address:	123 Street Address	First Name Last Name <input type="text" value=""/>
City:	Rochester	Medicare Information
State/Province:	New York	Do you or your family members have Medicare coverage? No
Zip/Postal Code:		Other Coverage Information

Select Coverage		Edit
Medical Group Number:		Have you or any of your family members had No coverage under another health or dental insurance carrier during the last 63 days?
Medical Enrollment Code:		
Dental Plan:	Declined	

If everything is correct, please click 'Submit'. To make any changes, use the 'Edit' links above.

- Verify that all dependents have the green check mark for coverage
- Otherwise the dependents will not be covered

Resent Submissions feature



A nonprofit independent licensee of the Blue Cross Blue Shield Association



Recent Submissions



Home **Enroll & Update** ^ Compare Plans v Billing v Data Reporting v Resources v

Enroll & Update

Group	Member
<ul style="list-style-type: none">New Group PaperworkRenewal Group PaperworkAnnual Group Information FormAdd/Activate/Remove Group NumberSummary of Benefits and Subscriber Contracts	<ul style="list-style-type: none">Enroll a New MemberView Member RosterView/Update PolicyReinstate Cancelled PolicyMember CardView DeductibleRecent Submissions

Recent Submissions

Home Enroll & Update ▾ Compare Plans ▾ Billing ▾ Data Reporting ▾ Resources ▾

Employers > Enroll & Update > Member > Recent Submissions

Recent Submissions

Search Options

From:  **To:** 

Subscriber ID/SSN:

Subscriber Last Name:

Recent Submissions

Select subscriber name to view the details of the enrollment transaction

[Additional Instructions](#)

Subscriber Name	Subscriber ID/SSN	Transaction Type	Status	Date Entered
Jane Doe	999999999	Cancel Coverage	Received	09-02-2020
John Doe	1111X1111	Cancel Coverage	Received	09-02-2020
Clark Kent	2222X2222	Change Coverage	Received	09-02-2020
		Enroll New Member	Received	08-31-2020

Additional Instructions

Close

- Click a column heading to sort results.
- Once processed, you can view these changes in our Member Roster.

Recent Submissions



Recent Submissions

Confirmation

[« Return to Previous Page](#)

Confirmation Number: 2020-08-31 12:09:01.076208

[Print This Page](#)

Subscriber Name:

Group/Employer Information

Employee Number:		Department Number:	
Employee Status:	Active	Hire Date:	09-01-2020
Desired Effective Date:	09-01-2020		

Subscriber Information

First Name:	Joe	Title:	
Last Name:	Smith		
Gender:	Male	Social Security Number:	999999999
Date of Birth:	11-22-1996		

Address Information

Street Address:	165 Court St.	Daytime Phone Number:	1 (607) 777-9999
City:		Email Address:	
State/Province:	New York		
Zip/Postal Code:	13326	Country:	United States

Recent Submissions

Select Coverage

Medical Group Number: 999999999
Dental Group Number: 111111111

Family Member Information

Persons Covered:	Excellus Blue PPO Signature Copay 1 10/10/50	Dental Plan
	✔	✔

Record of the Information entered in the enrollment transaction

Medicare Information

Do you or your family members have Medicare coverage? **No**

Other Coverage Information

Have you or any of your family members had **No** coverage under another health or dental insurance carrier during the last 63 days?

**Contact Us – Use Self Service Features
For the Most Efficient Service**



By Email For Name Change, SSN & DOB Updates

Contact Us

By Email | By Phone | By Mail | Visit Us In-Person

Follow these links to send a private, secure message to us. Our representatives will respond within **four business days**. If you need an immediate response, please call by telephone.

[Enrollment & Billing Support](#) ← **Use for name changes, date of birth, SSN, Reinstate back beyond the 31 days. Goes To Enrollment & Billing Support – most efficient method. Allow 2 – 5 business days**

Log in and use the Enrollment & Billing Support tool. Excellus BlueCross BlueShield remains secure.

Check Out Our Process for Enrollment & Billing Support.

If you do not have a login today, it's easy to request one:

- Go to employer.excellusbcbs.com/registration ← **Need back up coverage – get your security before it is needed.**
- Select the appropriate option
- Complete all fields; click 'Submit'
- Your request will be completed within 24-48 hours

[Add or Remove Group Numbers for Online Enroll & Update](#) ← **To Add/Remove or Activate Group Numbers Fill Out eForm**

- Prescription Drug Help Desk
- [Web Training/Support](#) ← **Training for Web Enrollment, Online Bill Pay or other Web Transactions**
- Technical Website Issues

By Phone

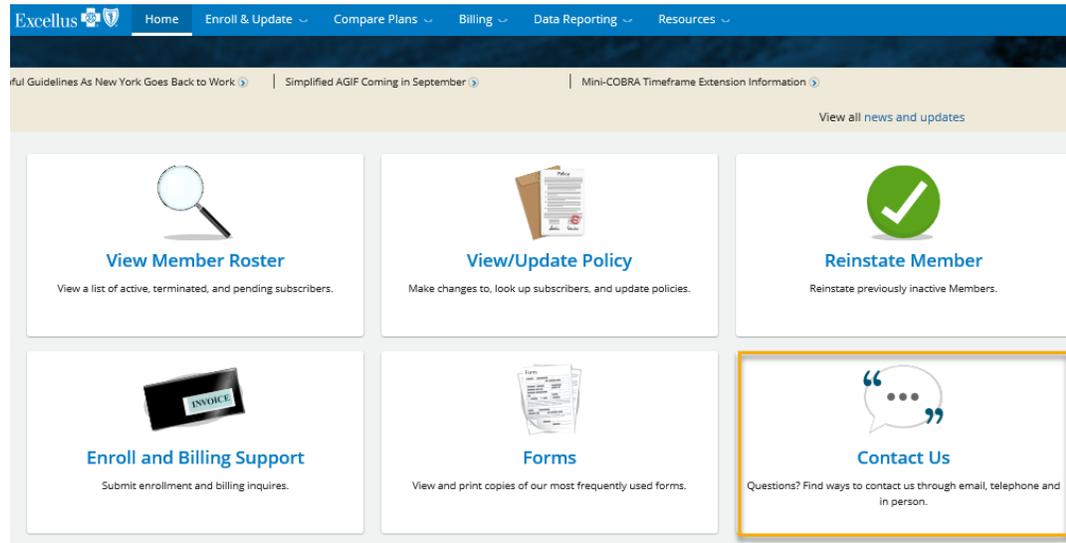
Contact Us

[By Email](#) **[By Phone](#)** [By Mail](#) [Visit Us In-Person](#)

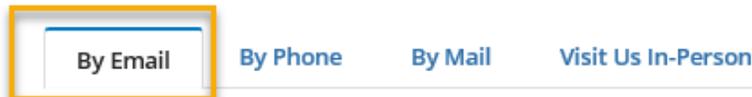
FOR QUESTIONS ABOUT:	CONTACT:
Commercial Large Group (50 or more eligible subscribers) Benefits, Setup, Updates, Cancellations, Billing, Member Enrollment or Member Cancellations	Call your dedicated Broker and/or Account Service Consultant
Commercial Small Group (Less than 50 eligible subscribers) Benefits, Setup, Updates, Cancellations, Billing, Member Enrollment or Member Cancellations	Call your dedicated Broker and/or Account Service Consultant
Technical Website Issues  Production issues, Access questions	Call our Web Help Desk at 1-800-278-1247 (Monday - Friday, 9 a.m. to 4:30 p.m. EST)
Member Claims, Benefits or Authorizations for Medical, Dental or Pharmacy Plans	Members should call the number on their Member ID Card.

Frequently Asked Questions

- Send name changes, updates to the Date of birth or the Social Security # to the Contact Us By email to Enrollment & Billing Support.
- Logon and select the link



Contact Us



Follow these links to send a private, secure message to us. Our representatives will respond within **four business days**. If you need an immediate response, please call by telephone.

[Enrollment & Billing Support](#)

Log in and use the Enrollment & Billing Support form to send all inquiries to Membership and Billing. SSL encryption ensures that the information transmitted between you and Excellus BlueCross BlueShield remains secure and, where applicable, that our member's information is not compromised.

Frequently Asked Questions

- Submit 1 New Enrollment or Change Coverage transaction for Medical, Dental and Rx coverages.
- Submit separate Medical and Dental enrollment when the policies have different effective dates.
- Use the links at the top of the Enrollment Transaction to enter enrollment for Medicare Advantage & Supplemental members

Please Note: Follow this link to [change/cancel coverage](#) for a **Medicare Advantage** or **Medicare Supplemental** member. View [Medicare Enrollment Forms](#).

- If you need to Reinstate beyond the previous 1st of the previous 30 days – Submit the to Enrollment & Billing Support, **slide 49**
- Submit address change per policy

QUESTIONS?



THANK YOU

