



**BlueCross BlueShield  
of New Mexico**

**PRODUCER OF RECORD TRANSFER FORM INSTRUCTIONS**

**IMPORTANT NOTES FOR COMPLETING THE FORM**

Producer of Record Transfer Form should include:

- ✓ Requested effective date of change
  - Future effective dates will be accepted *(retroactive transfer dates will not be accepted)*
- ✓ Group account name
- ✓ Group account number
- ✓ Signature by Group Administrator (include individual's Title)
- ✓ Producer Name and BCBS State Specific Producer # (do not use NPN or Tax ID)
- ✓ Indication of splits and amounts, **if applicable** (ie Primary Producer 1, 50%.....Secondary Producer 2, 50%)
- ✓ Total amount of split must equal 100%
- ✓ **Please ensure that the Group General Agent or AE is notified of this impending change**

**STEPS FOR Completing the Producer of Record Transfer Form**

Producer completes their portion of the form

Prints or electronically sends form to Group Administrator

Group Administrator (Admin) completes their portion of the form, signs and returns to Producer

Producer reviews and validates the form has been completed correctly

If secondary or sub-producer assignment is necessary, please ensure additional producer information is correct including any split percentage of commissions. Secondary splits are optional.

***PLEASE NOTE: Sub-producers will not be paid directly and cannot have a split amount assigned. They will always be 0%.***

**How to Submit Completed Form**

1. Log into Blue Access for Producers (BAP)
2. Got to Producer Services Tool
3. Choose "Update My Producer of Record"
  - Select "Line of Business" Group
  - Enter Group Account #
  - Enter Group Name
  - Choose File (upload completed form)
  - Select "Submit"
  - If upload was successful, you will be given a service ticket # for your records  
This ticket # can be tracked under "Existing Request Tickets"

Other available submission options:

1. Email completed form to directly to Producer Service Center - [Producer\\_Service\\_Center@bcbsok.com](mailto:Producer_Service_Center@bcbsok.com)
2. Email completed form to your Group Market Representative or General Agent
3. FAX completed form to the Producer Service Center @ 918-549-3039
4. Mail completed form to:  
Health Care Service Corporation  
c/o Producer Service Center  
PO Box 60545  
Oklahoma City, OK 73146



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# Producer of Record Transfer Form Group Markets

## Guidelines:

1. All fields are required. The request cannot be considered if the form is incomplete.
2. An electronic or wet signature is required by the Authorized Group Administrator.
3. The producer must provide the effective date. Producer will be notified of the effective date assigned for this Producer of Record Transfer request upon completion of processing. Retroactive transfer dates will not be accepted.
4. Blue Cross and Blue Shield of New Mexico reserves the right to limit transfers.

As the Group Administrator for the below mentioned account, I appoint as our organization's Producer of Record as of \_\_\_\_\_. I understand that our Producer must be appointed to sell insurance with Blue Cross and Blue Shield of New Mexico, and as such, maybe considered a Business Associate of Blue Cross and Blue Shield of New Mexico. The Producer may have access to certain information related to insurance support functions, such as membership maintenance information, plan benefit information, new product information and enrollment/dis-enrollment information.

In addition, I am aware that when the Producer is acting as a Business Associate of Blue Cross and Blue Shield of New Mexico, the Producer's access to my account's PHI maintained by Blue Cross and Blue Shield of New Mexico, excludes access to other types of information, including claim and/or medical information. However, if my Group Health Plan is HIPAA compliant, we may choose to execute an Insured Group Certification providing instructions and authorization to Blue Cross and Blue Shield of New Mexico to share PHI with our appointed Producer.

Authorized Group Admin Signature: \_\_\_\_\_ Date Signed: \_\_\_\_\_

Authorized Admin Printed Name: \_\_\_\_\_ Title \_\_\_\_\_

Group Acct Name: \_\_\_\_\_ Group Acct # \_\_\_\_\_

Primary Producer Name \_\_\_\_\_ Producer # \_\_\_\_\_

Sub-producer (if applicable) \* \_\_\_\_\_ Producer # \_\_\_\_\_

\*If split - Secondary Name /PR # \_\_\_\_\_ Producer # \_\_\_\_\_

PRIMARY Split % \_\_\_\_\_ /\*SECONDARY Split % \_\_\_\_\_ (must equal 100%)

**\*Secondary is optional and not required**

**Producer is responsible for submitting the completed form to one of the following:**

**Online:** via Blue Access for Producers under Producer Services, Self Service tool under "Request Assistance"

**Email:** [Producer\\_Service\\_Center@bcbsok.com](mailto:Producer_Service_Center@bcbsok.com)

**Fax:** 918-549-3039

**Mail:** Health Care Service Corporation  
c/o Producer Service Center  
PO Box 60545  
Oklahoma City, OK 73146