Blue Cross Blue Shield of Rhode Island

Electronic Payment Option Authorization to Cancel
Direct Pay Members

I/we request that I/we be removed from Blue Cross & Blue Shield of Rhode Island's Electronic Payment Option Plan for premium payments and be billed directly.

Date _____

Name (Please print) _____

Member ID # _____

Telephone Number _____

Signature _____

Please return this completed authorization form to:

Membership Dept. – EPO – Direct Pay
Blue Cross & Blue Shield of Rhode Island
500 Exchange Street
Providence , RI 02903-2699

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