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 rerum this completed authorization form to:

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

Blue Cross & Blue Shield of Rhode Island is an independent licensee of the Blue Cross and Blue Shield Association.

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