South Carolina

BlueChoice® HealthPlan South Carolina

Application For Clinic/Group/Institution/Location to File Claims or to Change Employer Identification Number (EIN)

Please complete this form to notify BlueCross BlueShield of South Carolina and BlueChoice HealthPlan of the creation of a new location that wishes to file claims for Preferred Blue® (PPC), BlueChoice HealthPlan, BlueChoice HealthPlan Medicaid, the State Health Plan and/or FEP. You must verify your EIN by submitting one of these: *Letter 147C, CP 575 E or tax coupon 8109-C*.

Please include a copy of the National Plan and Provider Enumeration System (NPPES) NPI notification with this application.
Note: Do not file claims to BlueCross with your NPI at this time. Continue to file claims with your BlueCross provider numbers only.

Fax the completed form and appropriate documentation to 803-264-4795. If you have questions about this form, email Provider.Cert@bcbssc.com.

This form does not qualify you to be a network provider.

(Please type or print)

Date of Request: ____________________

Name of Business: ____

Federal Tax ID (EIN): ______________________________ Effective Date: ______________________________

Date Clinic/Group Open for Business: ____________________ Previous Tax ID, if applicable: ____________________

If the new EIN is a result of a merger or acquisition, were the assets and liabilities purchased? (Yes, No or N/A) ____________

*National Provider Identifier (NPI): ____________________ Old NPI, if applicable: ____________________

Practice/Institution Location Address: Payment Address:

______________________________________ ______________________________________

______________________________________ ______________________________________

County: ______________________________ County: ______________________________

Practice Appointment Phone #: ____________________ Practice Fax #: ____________________

*Required

Type of Business:

- ☐ Professional Assoc/Clinic/Partnership
- ☐ General Acute Care Hospital
- ☐ Rehabilitation Institution
- ☐ Psychiatric Institution
- ☐ Alcohol/Substance Abuse Institution
- ☐ Durable Medical Equipment (DME)
- ☐ Skilled Nursing Facility
- ☐ Home Health Agency
- ☐ Hospice
- ☐ Pharmacy Only
- ☐ Pharmacy with DME Sales
- ☐ Other (Specify) ______________________________
- ☐ Independent Clinical Lab
- ☐ Physiological Lab
- ☐ Portable X-Ray Supplier
- ☐ Outpatient Diagnostic Ctr.
- ☐ Orthotics/Prosthetics

All professional associations, corporations, partnerships and clinics must complete this section:

Medicare Group #: ______________________________

List each practitioner who will be providing services at this location:

Name	Social Security #	NPI	Primary Specialty

All hospitals, institutions and other facilities must complete this section:

License #:____________________________ (attach copy of license)

Are you JCAHO accredited? ☐ No ☐ Yes (attach copy of accreditation)

Are you state certified? ☐ No ☐ Yes (attach copy of certification)

Are you cardiac rehabilitation certified? ☐ No ☐ Yes (attach copy of certification)

Member Certification #:____________________ Certification Date:_______________ (attach copy of Medicare certification)

Indicate the number of beds, excluding exempt units: _______________

All ambulance services must complete this section:

The ambulance company bills all patients for rendered services.	☐ Yes	☐ No
The ambulance company is a voluntary ambulance company.	☐ Yes	☐ No
The ambulance company is a government subsidized company.	☐ Yes	☐ No

Please check the appropriate boxes. I certify that the above named ambulance company meets the following requirements:

☐ Each of the company's ambulance vehicles are specially designed and equipped for emergency transportation of the sick or injured.

☐ The minimum ambulance crew consists of at least two members, one of whom has a minimum training at least equivalent to that provided by the advanced Red Cross First Aid course.

☐ The ambulance company agrees to notify BlueCross BlueShield of South Carolina and BlueChoice HealthPlan of any change in company ownership and/or operation which results in these:

- The use of vehicles as ambulances which are not specially designed and equipped for emergency transportation of the sick or injured.
- The minimum first aid requirement for crew members is less than the advanced Red Cross First Aid course equivalent.
- The political jurisdiction in which the ambulance company is based requires a license to operate an ambulance service within its jurisdiction.

All applicants must complete this section:

Date Legal Entity Established: ______________________________

List Each Owner:

Name	**Title**	**Social Security #**

Contact Person:____ Contact Person's Phone #:____________________________

Email Address (required for notification when we complete changes):____

Enter text directly into the form by placing your cursor on each blank. Click on boxes to select them, or tab to them and press your spacebar. You can also save this form to your computer. Use the "Clear Form" button on the first page to delete all answers. Print the form and fax it to us to complete your application.

BlueCross BlueShield of South Carolina and BlueChoice HealthPlan are independent licensees of the Blue Cross and Blue Shield Association.