



South Carolina

*BlueCross BlueShield of South Carolina  
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# Change of Address Form

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Use this form to update your **Physical** and/or **Pay to** addresses for Preferred Blue®, State Health Plan and FEP networks. If you are changing a Pay to address, for your protection this form must be signed by the provider or the CEO, CFO, Director of Finance or Director of Billing.

NAME: \_\_\_\_\_  
TAX ID # / NPI #: \_\_\_\_\_  
EFFECTIVE DATE: \_\_\_\_\_  
PHONE NUMBER: \_\_\_\_\_

OLD PHYSICAL ADDRESS: \_\_\_\_\_ NEW PHYSICAL ADDRESS: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

OLD PAY TO ADDRESS: \_\_\_\_\_ NEW PAY TO ADDRESS: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

SIGNATURE: \_\_\_\_\_

TITLE: \_\_\_\_\_ DATE: \_\_\_\_\_

E-MAIL ADDRESS: \_\_\_\_\_

(Required if you would like notice that the requested changes have been made.)

Please fax the completed form to Provider Certification at 803-264-4795.  
If you have questions about this form, you may send those questions to  
[Provider.Cert@bcssc.com](mailto:Provider.Cert@bcssc.com).