

Dear Provider:

Use the following forms to file claims to BlueCross BlueShield of South Carolina or to BlueChoice HealthPlan. There are three forms in this document.

1. **Health Professional Application to File Claims** (Required for individual practitioners)
2. **Application For Clinic/Group/Institution/Location to File Claims or to Change Employer Identification Number (EIN)** (Required for clinics, partnerships, professional associations, institutions and other provider groups)
3. **Authorization for Clinic/Group To Bill for Services** (Required when individual practitioners authorize benefit payment to a clinic, partnership, professional association or other provider group. Each practitioner must complete this form.)

Approval applications allow for the submission of claims. The forms in this document are not an application for managed care network participation.

Please fax the completed forms to 803-264-4795 or email to [Provider.Cert@bcbssc.com](mailto:Provider.Cert@bcbssc.com).

## Health Professional Application to File Claims

Complete this form to request the addition of a health professional to our database to enable that practitioner to file claims to BlueCross BlueShield of South Carolina and BlueChoice HealthPlan for Preferred Blue® (PPC), BlueChoice HealthPlan, BlueChoice HealthPlan Medicaid, the State Health Plan and/or FEP. **Please include a copy of the National Plan and Provider Enumeration System (NPES) 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, email Provider.Cert@bcssc.com. If you want BlueCross or BlueChoice HealthPlan to pay a clinic, group, professional association or institution, please complete the *Authorization for Clinic/Group to Bill for Services* form.

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

**(Please type or print)**

Name: _____	Date of Request: _____
Social Security Number: _____	Date of Birth: _____
*Federal Tax ID Number: _____	Effective Date: _____
*National Provider Identifier (NPI): _____	
Appointment Phone Number: _____	Fax Number: _____

**\*REQUIRED FIELDS**

<p><b>ADDRESS (Physical Location):</b></p> <p>_____ (Street)</p> <p>_____ (City) <span style="margin-left: 100px;">(State)</span></p> <p>_____ (ZIP) <span style="margin-left: 100px;">(County)</span></p>	<p><b>MAILING ADDRESS (Pay to Address):</b></p> <p>_____ (P.O. Box or Street)</p> <p>_____ (City) <span style="margin-left: 100px;">(State)</span></p> <p>_____ (ZIP) <span style="margin-left: 100px;">(County)</span></p>
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**ADDITIONAL PRACTICE LOCATIONS:**

_____ (Name)	_____ (Tax ID Number)	_____ (NPI)
_____ (Name)	_____ (Tax ID Number)	_____ (NPI)
_____ (Name)	_____ (Tax ID Number)	_____ (NPI)

License Number: \_\_\_\_\_  Temporary Limited  Permanent Language(s): \_\_\_\_\_

Issuing State: \_\_\_\_\_ Effective Date: \_\_\_\_\_

Medicare UPIN Number: \_\_\_\_\_ DEA Number: \_\_\_\_\_

Primary Specialty: \_\_\_\_\_ Board Certification Date: \_\_\_\_\_

Secondary Specialty: \_\_\_\_\_ Board Certification Date: \_\_\_\_\_

Medical School Graduated: \_\_\_\_\_ Year: \_\_\_\_\_

University Graduated: \_\_\_\_\_ Year: \_\_\_\_\_

Highest Degree: \_\_\_\_\_ Year: \_\_\_\_\_

Please give the date you began performing services for payment outside the scope of an intern or training program, after you completed your residency: \_\_\_\_\_

SIGNATURE OF PRACTITIONER: \_\_\_\_\_ EMAIL ADDRESS: \_\_\_\_\_  
(required for notification when we complete changes)

## 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@bcssc.com](mailto:Provider.Cert@bcssc.com).

**(Please type or print)**

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

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:

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

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
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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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: \_\_\_\_\_

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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.
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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.

## Authorization for Clinic/Group to Bill for Services

Please complete this form to notify BlueCross BlueShield of South Carolina and BlueChoice HealthPlan that you have authorized a clinic/group/institution/location to bill for your services for Preferred Blue<sup>®</sup> (PPC), BlueChoice HealthPlan, BlueChoice HealthPlan Medicaid, FEP and/or the State Health Plan. Fax the completed form to 803-264-4795. If you have questions, email Provider.Cert@bcssc.com.

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

BlueCross and BlueChoice HealthPlan reserve the right to accept or refuse authorization for a clinic/group/professional association/institution to bill for services.

**(Please type or print)**

Date of Request \_\_\_\_\_

I agree that \_\_\_\_\_ will bill for and receive charges or fees for my services  
(Name of Clinic, Group or Professional Association)

effective \_\_\_\_\_  
(Date: MMDDYYYY)

\_\_\_\_\_  
(Signature of Practitioner)

\_\_\_\_\_  
(Practitioner's Name Printed)

\_\_\_\_\_  
(Practitioner's Social Security Number)

\_\_\_\_\_  
(Practitioner's National Provider Identifier)

\_\_\_\_\_  
(Practitioner's License Number)

Clinic/Group/Professional Association/Institution Physical Address:

Payment Address:

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
(Signature of Clinic/Group/Professional Association/Institution Representative)

\_\_\_\_\_  
(Title of Clinic/Group/Professional Association/Institution Representative)

\_\_\_\_\_  
(Representative's Contact Telephone Number)

Email Address (required for notification when we complete changes)  
\_\_\_\_\_

Enter text directly into this 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 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.