

Request to Add or Terminate Practitioner Affiliation

Please complete this form to request the addition or termination of a health professional's association with your clinic, group, professional association or institution for BlueCross BlueShield of South Carolina or BlueChoice HealthPlan for Preferred Blue® (PPC), BlueChoice HealthPlan, BlueChoice HealthPlan Medicaid, FEP and/or the State Health Plan. ***This form should be completed no more than 30 days after the addition, termination or change.*** Fax the completed form to 803-264-4795.

If you are adding a provider not currently on file, you will also need to complete the *Health Professional Application to File Claims* and the *Authorization for Clinic/Group to Bill for Services*. If you have questions about this form, email Provider.Cert@bcssc.com.

(Please type or print)

Add Terminate

Date of Request: _____

Practitioner's Name: _____

Social Security Number: _____

Federal Tax ID Number (plus suffix, if applicable): _____ Effective Date: _____

National Provider Identifier (NPI): _____

Additional Tax ID Number:

Address:

Effective Date:

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

(Signature of Clinic, Group, Institution Representative)

(Print Name of Clinic, Group, Institution Representative)

(Signature of Clinic, Group, Institution Representative)

Email Address: _____ (Required if would like notice that the requested changes have been made)

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 to delete all answers. Print the form and fax it to us to complete your application.