

## AUTHORIZATION FOR CLINIC/GROUP TO BILL FOR SERVICES

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

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

BlueCross BlueShield reserves 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 effective  
(Name of Clinic, Group or Professional Association.)

\_\_\_\_\_  
(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)

E-mail Address (required for notification when we complete changes): \_\_\_\_\_