

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 for Preferred Blue® (PPC), State Health Plan and/or FEP. **Please include a copy of the National Plan and Provider Enumeration System (NPPES) NPI notification with this application.** Fax the completed form and appropriate documentation to 803-264-4795.

If you have questions, send them to Provider.Cert@bcbssc.com. If you want payments to be made to 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.)

Date of Request: _____

Name: _____

*Social Security Number: _____

Date of Birth: _____

*Federal Tax ID Number: _____

Effective Date: _____

*National Provider Identifier (NPI): _____

Appointment Phone Number: _____

FAX Number: _____

*REQUIRED FIELDS

ADDRESS (Physical Location):

MAILING ADDRESS (Pay-to Address):

(Street)

(P.O. Box or Street)

(City) (State)

(City) (State)

(ZIP) (County)

(ZIP) (County)

ADDITIONAL PRACTICE LOCATIONS:

(Name) (Tax ID Number) (NPI)

(Name) (Tax ID Number) (NPI)

(Name) (Tax ID Number) (NPI)

License Number: _____ Temporary/Limited _____ Permanent Languages(s): _____

Issuing State: _____ Effective Date: _____

Medicare UPIN Number: _____ DEA Number: _____

Primary Specialty: _____ Board Certification Date: _____ Exp. Date: _____

Secondary Specialty: _____ Board Certification Date: _____ Exp. Date: _____

Medical School Graduated: _____ Year: _____

University Graduated: _____ Year: _____

Highest Degree: _____ Year: _____

What date did you begin practicing for payment outside the scope of an intern or training program? (i.e., date you began practicing after you completed your residency) _____

SIGNATURE OF PRACTITIONER: _____

**E-mail Address: _____

**Required for notification when changes are complete.

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