



Independent licensees of the Blue Cross Blue Shield Association.

Provider Enrollment

Frequently Asked Questions

1. How does a practice change its legal business name?

To change the legal business name of the practice, the request can be sent via email to Provider.Blue.Updates@bcssc.com. The practice would need to include an updated IRS document showing the new name.

2. How does a physician change their name if they get married?

If a physician gets married and needs to change their name, they can submit their request via email to Provider.Blue.Updates@bcssc.com. The physician would need to include a copy of their marriage license.

3. Can a physician become part of any network?

No. Physicians can only join networks where their group is currently contracted. For instance, a physician may request to join State Health Plan, Medicare Advantage and Healthy Blue. However, if their group only has a contract with Preferred Blue, that is the only network the physician can join.

4. Does a physician need to be affiliated with all locations under a facility or practice?

No. If the physician is affiliated to the main location of the facility or practice, their claims will process for all associated locations. Physicians are only affiliated to facilities or practices where they are actively and regularly seeing patients.

5. What is needed to update the change of ownership for a practice?

If the tax identification number (TIN) or National Provider Identifier (NPI) has changed, new enrollment paperwork is needed. The practice would need to complete the Group Application.

If the owners change, but the TIN and NPI remain the same, the notification can be sent via email to Provider.Blue.Updates@bcssc.com.

6. Can provider affiliations be completed through M.D. Checkup?

Provider affiliations can only be completed through M.D. Checkup if the physician is already enrolled and associated with the base TIN of the practice.

If you are trying to affiliate a physician to a location under a different TIN, you would need to complete the Request to Add/Term Practitioner form.

Example:

- TIN A – 123456789
 - Location 1
 - Location 2

- TIN B – 987654321

Dr. Tommy is enrolled and associated with TIN A and works at location 1. He will begin seeing patients at location 2. Because he is already associated with the base TIN, you can complete the new affiliation through M.D. Checkup.

Dr. Tommy is enrolled, but not associated with TIN B. He will begin seeing patients at TIN B. Because he is not associated with TIN B, you would need to complete the Request to Add/Term Practitioner form.

7. Which enrollment applications and forms are used at BlueCross BlueShield of South Carolina?

The enrollment applications and forms used at BlueCross include:

Application or form	Used for...
Individual Enrollment	New practitioners that want to enroll with BCBSSC (not Behavioral Health)
Group Practice Enrollment	New groups that want to enroll with BCBSSC
Facility Information Request	Medical facilities that want to credential with BCBSSC
Virtual Care Services	Practitioners or groups that want to render telemedicine and telehealth services
Health Professional	<u>In-state, out-of-network</u> practitioners that want to file claims to BCBSSC
Behavioral Health	New practitioners or groups that want to enroll in our behavioral health network
Autism Provider Panel	Applied behavior analysts that want to enroll in our autism provider panel
DBA Name Change	Changing the doing business as (DBA) name of a practice
Change of Address	Updating the physical, pay to, correspondence and billing agency address
Satellite Location	<u>Enrolled groups</u> that have <u>new locations</u> that want to file claims
NPI Provider Notification	Registering an NPI with BCBSSC
Add or Terminate Practitioner	Adding or terminating a practitioner's affiliation with a clinic, group or institution

8. Are electronic signatures accepted?

Use the below tables to determine which documents can be signed electronically.

Medical Networks

Application or Form	Signature Requirements
Provider Enrollment	Electronic or wet
Recredentialing	Electronic or wet
Facility Information Request	Electronic or wet
Health Professional	Electronic or wet
Doing Business As (DBA)	Electronic or wet
Change of Address (CoA)	Electronic or wet
Add/Term Practitioner	Electronic or wet
Authorization to Bill	Electronic or wet
Electronic Funds Transfer (EFT)	Wet
Appendix D (BlueChoice® HealthPlan)	Wet
Hold Harmless (BlueChoice® HealthPlan)	Wet
ALL Contracts	Wet

Behavioral Health Networks

Application or Form	Signature Requirements
Behavioral Health	Electronic or wet
Autism Panel	Electronic or wet
Facility Information Request	Electronic or wet
Authorization to Bill	Electronic or wet
ALL Contracts	Electronic or wet

9. Can a 'DO' provider specialty type join the Healthy Blue network?

No. Providers with the specialty of 'DO' (other) cannot join the Healthy Blue network as a true specialty type is needed. This specialty is used for us to verify our FQHC/RHC locations. They are not actual locations that offices can request to be loaded. Each 'DO' location must have a corresponding multi-specialty location with the same address on file.

10. How does the recredentialing process work?

Recredentialing occurs every three years. Our credentialing team makes outreach when the provider's recredentialing date is approaching.

First, the credentialing team calls to see if the provider is actively working at the location on file. If so, the application is sent via email or fax. If a response is not received after the first attempt, a second attempt is made in 14 days. If a response is not received after the second attempt, a third attempt is

made in seven days. If no response is received after the third (final) attempt, the status change process begins.

If the provider misses their recredentialing date, they will be termed, and new enrollment will be required.

11. How long does the enrollment process take?

Currently, it can take up to 120 days for a clean application (meaning all required documentation along with applicable signatures, initials and dates has been received) to process. If there are any missing items, outreach is completed, which could extend the period as the review process cannot move forward without the requested information.

12. How long do providers have to provide missing items?

When applications are missing items, outreach is made every seven days with a 21-day max. If the missing items are not received within 21 days, the case will be canceled due to incomplete submission. At this point, a new application will need to be submitted.

13. How can I check the status of a submitted application?

If the application was submitted through our historical route (email or fax), you can call 800-868-2510 and select option 5. You can also submit a [status request](#) online.

If the application was submitted through [My Provider Enrollment Portal](#), you can verify the status under My Forms.

14. How can a provider update their TIN?

To update the TIN, the provider would need to complete a new Individual or Group application.

15. How can a provider update their NPI?

To update the NPI, the provider would need to complete a new Individual or Group application.

16. Are providers automatically enrolled in telehealth?

No. Providers would need to complete a separate Virtual Care application to be considered for telehealth services.

17. What is the difference between the effective date and the affiliation date?

The effective date is the date that the provider is approved by the Credentialing Committee and this date cannot be changed.

The affiliation date is the date in which a provider can render services with an established group. This date can be backdated 45 days from the day we receive all required documentation. Any date past 45 days will require a claim to be submitted with the requested backdate as the date of service to show the provider was rendering services with the group at the time of approval.

For requested dates greater than 45 days, if the application is pending, email a copy of the claim to Provider.Requested.Info@bcpsc.com. If the application is completed, fax a copy of the claim to 803-264-4795.

18. How often do providers have to validate their demographic information?

With the implementation of the No Surprises Act which went into effect on Jan. 1, 2022, providers are required to validate their demographic data at least every 90 days. If more than 90 days has passed since the providers' last validation, we are required to suppress them from our directories.

19. Which provider types are not credentialed by BlueCross?

BlueCross will not credential the below provider types. Note: this list may not be all inclusive.

Acupuncturists	Associate Counselors	Christian Science Practitioners	Diabetes Education	Dieticians	Education Specialists
Homeopaths	Lay Midwives	Massage Therapists	Naturopaths	Occupations Therapy Assistants	Physical Therapy Assistants
Psychology Assistants	Recreational Therapists	School Psychologists	Speech Therapy Assistants	Sports Trainers	Technicians

20. What happens if a location is closed through M.D. Checkup?

If a location is closed in M.D. Checkup, it will be closed in our claims system. Only complete this action when you truly want to terminate the location. Once a location is terminated, it cannot be undone, and providers would have to complete a new Satellite Location application.