Introduction

The enrollment process is performed for several reasons:
• To ensure we have accurate and complete information on providers as well as the practice they are joining.
• To verify providers are in good standing.
• To confirm providers meet requirements.
• To validate practitioners’ qualifications.

To begin the provider enrollment process, each provider must complete the Provider Enrollment Application and submit required documentation.

This presentation will outline that process.
BlueCross BlueShield of South Carolina, BlueChoice HealthPlan and Healthy Blue have streamlined the Provider Enrollment Process to improve the enrollment experience. We have developed a new webpage and new email addresses to ease the navigation of enrollment and reduce the number of incomplete applications.

The email address Provider.Cert@bcbssc.com will no longer be supported beginning Feb. 15, 2019. Please note the website and email addresses provided. Please use them for enrollment, return documentation and updates.

• Provider Enrollment Webpage – https://web.southcarolinablues.com/providers/providerenrollment.aspx
• Initial Enrollment Applications – Provider.Blue.Enroll@bcbssc.com
• Returning Documentation – Provider.Requested.Info@bcbssc.com
• Provider Demographic Updates – Provider.Blue.Updates@bcbssc.com
• Re-credentialing – Recred.App@bcbssc.com
Provider Enrollment Process

To ensure that you are submitting a complete provider enrollment packet, please visit

https://web.southcarolinablues.com/providers/provider enrollment.aspx

Here you will find instructions on how to enroll a new medical provider, a behavioral health provider, or a dental provider.

You will also find instructions on updating demographic information, how to re-credential an existing provider along with the forms required for these updates.
Clean Application Enrollment Process

1. We receive the application.
2. We review the application to ensure it is complete and includes all required documentation.
3. We send “clean” applications to the Credentialing Committee for review.
4. If the Credentialing Committee approves the application, we send a notification via email and mail a welcome packet to the provider.
5. If the Credentialing Committee does not approve the application, it is sent to the Provider Disciplinary Committee.
6. The Provider Disciplinary Committee either approves or denies the application.
7. We send a notification to the provider.
Provider Enrollment Process

To enroll a new provider, click on **New Provider/Initial Enrollment**.

**New Provider/Initial Enrollment**
Enroll with BlueCross BlueShield of South Carolina and BlueChoice HealthPlan

**Behavioral Health Enrollment**
Enroll in our mental health and substance abuse network

**Practice Enrollment**
Enroll your physical location with BlueCross and BlueChoice®

**Laboratory Enrollment**
Enroll in our laboratory network through Avalon
**Provider Enrollment Process**

Here you will find the enrollment steps along with checklists specific to each provider type.

1. Click on the provider type of the provider you are enrolling to access the checklist. This will ensure you have all necessary documents.

2. Complete all necessary forms.

3. For all networks you are applying for, you will need contract pages. Click here to request the contract pages and they will be sent directly to you.

4. Submit completed enrollment applications to Provider.Blue.Enroll@bcbssc.com

The enrollment process will begin when all items are received and complete.
Provider Enrollment Checklists

Check lists are fillable and include hyperlinks to the actual forms.

The enrollment process will begin when all items are received and complete.
We have included an interactive Provider Enrollment Checklist in the application. Each requirement is linked with a form or example. This checklist outlines each form that is required for each provider type. Mid-Levels are required to complete the full application for Healthy Blue (Medicaid). An abbreviated two-page application is required for Commercial networks.
We have a new form that replaces the S.C. Uniform Credentialing Application. This is the Provider Enrollment Application.

Check all networks that you wish the provider to join.

Completed applications should be faxed to 803-870-8919 or emailed to:

Provider.Blue.Enroll@bcbssc.com
This page requests information regarding the practitioner's personal information, medical/professional education and professional training.

Section 1 – the ECFMG # is the number assigned to foreign medical graduates.

Section 1 - The date the provider will start working for your practice is required.

Section 3 - if this section is not applicable, you must check the box.

Please note that ALL pages now require provider initials and date.
Provider Enrollment Application

This page requests information regarding the practitioner's state license, specialty board certification and hospital privileges.

Section 5 – if this section is not applicable you must check the box.

Section 5 - Education and specialty must match.

Section 6 - Include a Do Not Admit Plan (if applicable). This must be a written description of the hospital admitting arrangement.

Section 6 - CRNAs are not required to complete this section.

Please note that ALL pages now require provider initials and date.
Provider Enrollment Application

This page requests information regarding the practitioner's Work History.

**Five Year Work History** must be in the following format: month/year to month/year.

Do not include the day. If no end date, indicate “to present”

For any gaps of longer than six months, an explanation of that gap is required.

A CV cannot be used in place of this section.

Please note that ALL pages now require provider initials and date.
Provider Enrollment Application

This page requests information regarding the practitioner's primary practice location, office hours, billing address and patient population demographics.

Section 8 - Please indicate if you would like the provider to display at this location in our directory.

Please include the practitioner’s Medicaid ID number if they are applying for the Medicaid network.

Please note that ALL pages now require provider initials and date
This page requests information regarding the practitioner's additional practice locations, office hours, billing address and patient population demographics.

If the practitioner has no additional locations, please check the box at the top of the page.

If the practitioner has several additional locations, make copies of this page and complete for each site.

Please note that ALL pages now require provider initials and date.
Pages 4 and 5 are critical for ensuring that your practitioners are listed accurately in our Provider Directory.

A practitioner can be affiliated to as many locations as needed. However, you should only check this box if the practitioner is actively taking appointments at a location. If this box is checked, this practitioner will display at this location in our directory.
Pages 4 and 5 are critical for ensuring that your practitioners are listed accurately in our Provider Directory.

Patient population information is also displayed in the Provider Directory. Please make sure this information is accurate.

<table>
<thead>
<tr>
<th>PROVIDER PATIENT POPULATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does this provider see patients at this location? □ Yes □ No</td>
</tr>
<tr>
<td>Individual Medicaid #:</td>
</tr>
<tr>
<td>Are there patient age limitations? □ Yes □ No</td>
</tr>
<tr>
<td>Are there patient gender restrictions? □ Yes □ No</td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

Please describe any other patient limitations:
This page must be completed by the provider.

In order for the enrollment process to begin, any box checked “Yes” must be accompanied by a detailed written explanation.

Attachments can be included, but a written explanation is also required.

All answers will be validated, confirmed and reviewed.

Please note that ALL pages now require provider initials and date.
This page must be completed by the provider.

Use this page to respond to any questions answered “yes” to on the previous page.

Prewritten explanations may be attached in place of this page being completed.

Please note that ALL pages now require provider initials and date.
This page must be signed and dated.

Electronic signatures are acceptable for this page.

Signature date must be less than 150 days old.

Submit completed application along with required forms to Provider.Blue.Enroll@bcbssc.com
Or fax them to 803-870-8919
If you need help with the provider enrollment process, question can be submitted using the Provider Enrollment Assistance Form. You will receive a response within two business days.

This form can be located by clicking on New Provider/Initial Enrollment.
New Webpage for Provider Enrollment

Scroll to the bottom of the page and click on “Contact Us”.

New Provider/Initial Enrollment

Thank you for deciding to enroll with BlueCross BlueShield of South Carolina and BlueChoice HealthPlan. We here at BlueCross and BlueChoice® partner with physicians, facilities and other health care professionals to provide our members with quality, accessible and affordable health care services. If you are a new provider wishing to enroll, please use the checklist to find the forms and documents necessary for provider enrollment, including examples, or select the packet based on specialty. We look forward to teaming up with you!

Four Easy Steps to Join:

1. Use the checklist to find the forms you need based on your specialty
   a. NP, PA, CRNA, CNM, CNS and hospital-based physicians (Mid-level)
   b. Physician (MD/DO)
   c. DDS
   d. DMD
   e. Ancillary/Therapist
   f. Chiropractor
2. Fill out the appropriate forms, and collect required documentation
3. Request network contract pages
4. Submit a completed application with all required signatures and documentation to Provider.Blue.Enroll@bcbssc.com

When You Will Hear From Us:

1. When we receive your entire application
2. If we need any additional documentation
3. When your application is moving to the onboarding process
4. When your enrollment is complete

Still need help? Contact Us.

BlueChoice® HealthPlan is an independent licensee of the Blue Cross and Blue Shield Association.
Why did we move to using this form vs. free form emails?

Free form emails often did not contain enough information for us to answer your questions.

This form contains all of the information needed to accurately and efficiently respond to your inquiries.

Complete and hit “submit”.

Someone will contact you within two business days.
Dental Credentialing

Dental credentialing is for the Participating Dental and State Dental Plus networks.

Other plans that use the Participating Dental Network include:
- BlueCross Federal Employee Program (FEP) BlueDental℠
- FEP Basic and Standard
- GRID members

For **Initial Credentialing** use the South Carolina Dental Credentialing Application. This form can be located under the check list for DDS and DMD.

**Re-credentialing** occurs every three years. Use the same credentialing application for this process.

Fax completed applications, documentation and contract signature page(s) to 803-870-8919.
Behavioral Health Credentialing

Companion Benefit Alternatives (CBA) coordinates credentialing for mental health practitioners. CBA is a separate company that administers mental health and substance abuse benefits on behalf of BlueCross and BlueChoice HealthPlan.

Complete these steps to enroll with CBA.

Return completed applications by **mail** or **fax**.

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**Join The Mental Health Network**

Companion Benefit Alternatives, Inc (CBA) handles credentialing for mental health practitioners for the CBA and BlueCross BlueShield of South Carolina networks. CBA is a separate company that administers behavioral health benefits on behalf of BlueCross.

Here is a checklist of the tasks you must complete for credentialing:

1. Read, complete, sign and return the [CBA Practitioner Credentialing Application](#).
2. Read, sign and return the CBA Professional Agreement.
   (Please email [CBA.ProvRep@companiongroup.com](mailto:CBAProvRep@companiongroup.com) to request this document.)
4. Enclose a copy of the S.C. State License(s).
5. Enclose a copy of the DEA License(s) (if applicable).
6. Enclose a copy of the protocol (Nurse Practitioners only).
7. Enclose proof of current malpractice coverage.

Please return the completed application to:

- Companion Benefit Alternatives, Inc.
  ATTN: Network Coordinator AX315
  P.O. Box 100185
  Columbia, SC 29022
- Fax: 803-714-0456
A separate application is required for Behavioral Health providers.

Please complete this application and return to CBA.

If you have questions, please contact CBA at 800-868-1032, ext. 25744.

Return completed applications by mail or fax.
In late spring 2019, behavioral health providers will be able to apply via an online application at www.companionbenefitalternatives.com.

General Inquiries: cba.provrep@companiongroup.com
New VRU Option for Provider Credentialing

If you want to check status of a previously submitted application or if you have received correspondence on your application and have questions, you can now utilize the VRU

- Dial the Provider Services at 1-800-868-2510. The new option for Provider Enrollment says, “For Provider Enrollment, including credentialing, questions and inquiries, press 5.”

- The recording will then give you two options to choose from:
  - To begin the provider enrollment process, please go to the Provider Enrollment sections of SouthCarolinaBlues.com to find a Checklist of the information, documentation and required forms to be submitted to us as one Complete Enrollment Packet for consideration to join our networks. If you want to check the status of a previously submitted application, press 1.
  - If you have received correspondence on your application and have questions, or need any other Provider Enrollment assistance, press 2.

- The phone lines will be available Monday through Friday from 8 a.m. to 5 p.m.

- All calls received after 5 p.m. will be routed to the Provider Services area or a message will tell the providers to call back during regular business hours.

- There will not be a voicemail option. This line is for credentialing questions only.
Demographic updates are essential to the success of your practice.

You can make updates easily through Medical Directory Check Up (M.D. CheckUp).

Just click on “Let Us Know” to access Medical Directory Check Up.

- **Behavioral Health Enrollment**
  Enroll in our mental health and substance abuse network

- **Laboratory Enrollment**
  Enroll in our laboratory network through Avalon

- **Provider Demographic Updates**
  Update demographic information for your practice and physicians

- **Forms Library**
  Find the forms necessary for the provider enrollment process
Demographic Updates

This page provides instructions on accessing and updating your information.

Medical Directory Checkup allows you to view information for all of the associated locations as well as the affiliated practitioners for each location.

You’ll have the opportunity to update information at any time however; we will require verification for each location on a quarterly basis as follows:

January 1 – March 31
April 1 – June 30
July 1 – September 30
October 1 – December 31

Provider Demographic Updates

Log in to My Insurance Manager or register for My Insurance Manager and use MD Checkup to make demographic updates quickly and easily.

Use MD Checkup to:
1. Update the practice address
2. Change or add where an already-enrolled physician practices within your group (must have the same tax ID)
3. Terminate a provider
4. Update office/directory information

Other Provider Updates

- Authorization to Bill - Add a practitioner affiliation to a new group
- Change of Address Form - Update billing address(es)
- DBA Name Change Form - In order to update the Legal Business Name (LBN) for a provider group, we require a copy of the most current official IRS letter for the entity. Examples include an IRS LTR 147C, CP207, CP 575 A, CP 575 E, CP-224 or tax coupon 8109-C. Send to Provider Blue Updates@bcbsnc.com. W-9s are not accepted.
- EFT and ERA Enrollment Form/EFT Terms and Conditions
- Request to Add or Terminate Practitioner Affiliation - Add, terminate or change practitioner affiliation
- Satellite Location Application - Add a new location to file claims to an existing group or change your tax identification number.
- Medicare Advantage Offshore Subcontracting Attestation - Use and submit this form to BlueCross if your practice/facility utilizes offshore subcontractors.
Demographic Updates

This tool is available within My Insurance Manager™. This feature allows you to verify your practice and physician demographic information seamlessly. You will be able to:

**Verify** – Information shown is current and accurate. Verify is the final step to confirming revisions and to attest that no further action is needed for the quarterly verification.

**Update** – Once a change has been made, Update must be selected to confirm and accept the change.

**Remove Location** – Enter or select a date to indicate that a location shown in the Location List is no longer active or part of the organization.

**Remove Practitioner** – Enter or select a date to indicate that a practitioner is no longer participating with the specific location.

**Add Practitioner** – Add a practitioner to the specific location by using the Add Practitioner’s search function.

**View & Edit** – Access and edit location information (addresses, telephone number, fax number, hours of operation, etc.).
Demographic Updates

Why are these updates so critical? You could be losing patients!

Keeping the provider directory accurate and up to date is essential to the health plan and to the providers.

From the health plan’s perspective – the health plan as well as CMS conducts “secret shoppers” to audit the accuracy of the directory. The health plan is scored on the accuracy of the information displayed in the directory.

From the provider’s perspective - If provider data is incorrect or outdated, you could be losing patients.

If you receive the notice to update your demographic information, please do not just click accept without fully reviewing the information.

If you are not the correct person that should be reviewing this data, please send this to the appropriate person who can accurately validate.
Demographic Updates

Common Errors Found During Secret Shopper

• Appointment phone numbers are incorrect – a patient calls and cannot reach the office to make an appointment. Patients will choose to call another practice.
• Practitioners are listing at a location where they do not practice – a patient calls to schedule an appointment with a certain practitioner. They are told he is not at this location. Patients get frustrated and may choose another practice.
• Practitioners listed as accepting new patients – patients call to make a new patient appointment and are told that physician’s panel is closed. Patients get frustrated and may choose another practice.

How can you avoid these errors?
Update often! The process is easy and can be done at any time. You can update as soon as you learn of a change in your practice.
Demographic Updates

The **Location Details** screen shows the practice details:

- Address
- Telephone
- Fax
- Email
- Website
- Hours of operation
- Affiliated practitioners

The **Edit** function allows users to modify the information shown.
Demographic Updates

If you click on Remove Location, you are closing out that location in our system as well as removing it from the directory.
Re-credentialing

Established providers are required to re-credential every three years.

You can access the forms necessary to re-credential by clicking on “Established Providers/Re-credentialing”.

- **Provider Demographic Updates**: Update demographic information for your practice and physicians
- **Forms Library**: Find the forms necessary for the provider enrollment process
- **Established Providers/Re-credentialing**: Learn how to get re-credited
- **Out-of-State Providers**: Find the forms you need to bill South Carolina as an out-of-state provider
Re-credentialing

Our credentialing staff will notify you when it is time for you to complete this update.

The re-credentialing process consists of a 5 page South Carolina Uniform Managed Care Practitioner Credentials Update Form. This is an abbreviated version of the Provider Enrollment Application, so the same guidelines apply:

- Office/credentialing contact, phone number and email address is needed.
- Hospital Admitting information is required. If the provider does not admit, an admitting plan must be submitted.
- Providers will need to submit a copy of their malpractice coverage that will not expire within 30 days.
- If the provider answers Yes to any question on page 2, a detailed explanation is required.
- Signature dates on page 2, 3 and 5 must be less than 150 days old.
**SOUTH CAROLINA UNIFORM MANAGED CARE PRACTITIONER CREDENTIALS UPDATE FORM**

(Note: The following information will be held strictly confidential.)

### I. DEMOGRAPHIC DATA
A. Name in Full: 
B. Practice Name: 
C. Primary Care Physician: Yes No 
D. Social Security Number: 
E. Tax ID: 
F. Address: 
G. Email Address (required): 
H. Primary Admitting Facility: 

### II. CERTIFICATION/EDUCATION UPDATE
A. Are you currently board certified? Yes No 
B. Certified by American Board of: 
C. Medical School: Month/Year of Graduation: 
D. Professional License Number Where Currently in Practice: 

### III. PLEASE ANSWER THE FOLLOWING QUESTIONS
Managed Care Organizations must have updated facility information and written explanations to begin the re-credentialing process. If you answer "Yes" to any of the questions listed below, please enclose a detailed explanation:

1. Do you have any pending misdemeanor or felony charges?
2. In the past three years have you been convicted of a felony?
3. In the past three years has your license to practice medicine in any jurisdiction been voluntarily or involuntarily denied, restricted, suspended, challenged, revoked, conditioned or otherwise limited?
4. In the past three years and up to and including the present, have you had any ongoing physical or mental impairment or condition which would make you unable, with or without reasonable accommodations, to perform the essential functions of a practitioner in your area of practice, or unable to perform those essential functions without a direct threat to the health and safety of others?
5. Considering the essential functions of a practitioner in your area of practice, in the past three years and up to and including the present, have you suffered from any communicable health condition that could pose a significant health and safety risk to your patients?
6. In the past three years have you been publicly reprimanded or disciplined by a professional licensing agency or board?
7. In the past three years has your DEA certification or state-controlled drug permit been restricted, suspended, revoked, voluntarily relinquished or otherwise limited?
8. In the past three years have any of your privileges or memberships at any hospital or institution been denied, suspended, revoked, reduced, revoked, not renewed or otherwise limited?
9. In the past three years has your participation in Medicare, Medicaid or any other government program been limited or curtailed, or have you voluntarily excluded yourself from any of these programs?
10. In the past three years has your participation in an Insurance Company network been limited or terminated?
11. In the past three years and up to the present, have you had a history of chemical dependency or substance abuse that might affect your ability to competently and safely perform the essential functions of a practitioner in your area of practice?
12. In the past three years and up to and including the present, have you had or do you have any mental or physical condition or do you take any medications that might affect your ability to competently and safely perform the essential functions of a practitioner in your area of practice?
13. In the past three years has any malpractice carrier made an out-of-court settlement or paid a judgment of a medical malpractice claim on your behalf, or are any medical malpractice suits pending against you?
14. In the past three years has your professional liability insurer placed conditions or restrictions on your coverage or ability to get coverage?

(The above information will be held strictly confidential.)

Signature: 
Date: 

Please Print Name: 

**Must be signed on ink. EACH SUBMISSION REQUIRES AN ORIGINAL SIGNATURE AND CURRENT DATE. Rubber Stamped and Electronic Signatures Are Not Acceptable.**

Practitioners have the right to review information obtained to evaluate their credentialing and recredentialing applications.
Re-credentialing Application

IV. AUTHORIZATION:

I CERTIFY THAT ALL INFORMATION CONTAINED IN THIS CREDENTIALS UPDATE FORM AND ALL ITS ATTACHMENTS ARE ACCURATE, COMPLETE AND TRUE.

I understand that:

A. Any misrepresentation, misstatement or omission of a relevant fact in connection with this application may result in denial of my application or termination of my participation in the Managed Care Organization.
B. It is my responsibility to promptly advise the Managed Care Organization in writing within 30 days of any changes or additions to the information contained in this application.
C. All the information contained in this application or attachments is subject to the Managed Care Organization’s investigation and review.

NOTICE: The National Practitioner Data Bank may be queried. If you are not re-certified for reasons relating to professional conduct or professional competence, which reasons include misrepresenting, misstating or omitting a relevant fact in connection with your credentials, the rejection may be reported to The National Practitioner Data Bank.

I authorize the Managed Care Organization to consult with administrators and members of the medical staffs of hospitals or institutions with which I have been or am currently associated, and with others, including, without limit, past and present malpractice carriers, who may have information bearing on my professional competence, character and ethical qualifications. I further consent to the inspection by agents, employees, contractors, affiliates or other representatives of the Managed Care Organization of all documents that may be material to an evaluation of my professional competence, character and ethical qualifications. A PHOTOCOPY OF THIS DOCUMENT SHALL BE EFFECTIVE.

I release from liability the Managed Care Organization and all representatives of the Managed Care Organization for their acts performed in good faith and without malice or negligence in connection with evaluating my application and my credentials and qualifications, and I release from any liability any and all individuals and organizations who provide information to the Managed Care Organization in good faith and without malice or negligence concerning my professional competence, character and ethics. I consent to the release and exchange of information as allowed by law relating to any application, investigation, disciplinary action, suspension or revocation or participating status, membership and/or privileges of any type to or from the Managed Care Organization.

If I am re-certified by the Managed Care Organization, I consent to the Managed Care Organization’s inspection of my patient records as allowed by law, necessary for its peer and utilization review and quality assessment purposes and agree to be bound by the Managed Care Organization’s participation agreement, credentialing plan, policies, procedures and provider manual.

SIGNATURE: _______________________ DATE: _______________________

EACH SUBMISSION REQUIRES AN ORIGINAL SIGNATURE AND CURRENT DATE.
ELECTRONIC AND RUBBER STAMPED SIGNATURES ARE NOT ACCEPTABLE.

V. ADDITIONAL SATELLITE OFFICE INFORMATION

| Satellite Office #1 Address: | Office #1 Phone: |
| Office #1 Fax: |
| Office Contact Person: |
| Satellite Office #2 Address: | Office #2 Phone: |
| Office #2 Fax: |
| Office Contact Person: |
| Satellite Office #3 Address: | Office #3 Phone: |
| Office #3 Fax: |
| Office Contact Person: |
| Satellite Office #4 Address: | Office #4 Phone: |
| Office #4 Fax: |
| Office Contact Person: |
| Satellite Office #5 Address: | Office #5 Phone: |
| Office #5 Fax: |
| Office Contact Person: |
| Satellite Office #6 Address: | Office #6 Phone: |
| Office #6 Fax: |
| Office Contact Person: |
## Re-credentialing Application

### Attestation of Hospital Privileges

<table>
<thead>
<tr>
<th>Hospital Name</th>
<th>City/State</th>
<th>Statute of Privileges: (Active, Courtesy, Consulting, etc.)</th>
<th>% of Inpatient Admissions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>&quot;Pending&quot; or &quot;Applied for&quot; are not acceptable</td>
<td></td>
</tr>
</tbody>
</table>

Are your hospital privileges active and in good standing?  
[ ] Yes  
[ ] No  
If you do not admit, please describe arrangements to provide hospital care:  

### Authorization

I certify that all information contained in this attestation is accurate, complete and true.

I understand that:

a. Any misrepresentation, misstatement or omission of a relevant fact in connection with this attestation may result in denial of my application or termination of my participation in the network.
b. It is my responsibility to promptly advise BlueCross BlueShield of South Carolina and BlueChoice HealthPlan in writing within 30 days of any changes or additions to the information contained in this attestation.
c. All the information contained in this attestation is subject to BlueCross BlueShield of South Carolina's and BlueChoice HealthPlan's investigation and review.

Name:  

Signature:  

Date:  

Each submission requires an original signature and current date. Rubber stamped signatures are not acceptable.

BlueCross BlueShield of South Carolina and BlueChoice HealthPlan are independent licensees of the Blue Cross and Blue Shield Association.
Applications with Missing Documentation

The provider enrollment process will only begin once all required documentation has been received.

Should we receive an application that is incomplete or missing any documentation, we will contact the office and/or credentialing contact listed on the Provider Enrollment Application. This notification of missing items will be made within seven days of receipt of the application.

Outreach will be made to the provider for 30 days in an attempt to collect the missing items. If missing items are not received within that 30 days the application will be returned, the enrollment process closed for that provider and a new enrollment form will be required to re-start the enrollment process.
Applications with Missing Documentation

Why submit a complete application?

65% of enrollment applications are received incomplete!

The enrollment process will NOT begin until all enrollment items have been received.

Even if just one item is missing, the process will not begin until that one item is received.

The enrollment process is NOT started while the health plan is waiting on missing items.

Signature pages as well as effective dates for certain documents can expire while the application is awaiting the missing items.

Complete applications can be processed within 21 days.
Application Processing

The effective date will be the date the Credentialing Committee approves the application. Per Utilization Review Accreditation Commission (URAC) requirements.

Back dating of network dates set by committee are not allowed. Affiliation dates can be reviewed on an individual bases with claims documentation.

Once we approve your application, we will send a notification email to you within a couple of days of the Credentialing Committee approval, followed by a welcome packet.

The credentialing committee reviews all submitted documentation to ensure providers meet credentialing criteria, which includes a long list of items that need to be satisfied according to URAC, the National Committee for Quality Assurance (NCQA) or South Carolina’s Department of Health and Human Services (SCDHHS).

The Credentialing Committee approves or denies an application based on all of the information above.