BlueCross BlueShield of South Carolina and BlueChoice® HealthPlan of South Carolina

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:_____ Date of Birth:_____

B. Practice Name:_____

Primary Care Physician: ☐ Yes ☐ No Specialty:_____

C. Social Security Number:_____ NPI:_____

Tax ID:_____ Group NPI:_____

Medicaid ID: _____ CLIA Number: _____

Gender, Race, Ethnicity: (OPTIONAL). This information will not be used to make a determination regarding your network participation

__ Male __ Female Race: _____ Ethnicity: _____

D. Address:_____

Office (appointment) Phone Number:_____ Office Fax Number:_____

Office Credentialing Contact Person:_____ Contact Number:_____

Credentialing Contact Email Address (required):_____

E. Primary Admitting Facility:_____

Are your hospital privileges active and in good standing? ☐Yes ☐No

If you do not admit, please list your admitting plan or the physician that covers your hospitalized patients:

_____

Additional languages spoken will be published to the provider directory to help members select providers who meet their language needs.

Do you speak any foreign languages fluently? __Yes __ No

☐ Yes ☐No If so, please specify:_____

Are you accepting new patients? ☐Yes ☐No

Do you currently accept Medicaid? ☐Yes ☐No

Are there gender restrictions?

☐ Male Only ☐Female Only ☐Both/No Restrictions

Are there any age limitations? __Yes No __ If Yes, Minimum Age: __ Maximum Age: __

Please describe any other patient limitations: _____

Please enclose a copy of your current malpractice coverage.

Carrier Name:_____ Effective Dates: From_____To_____

Amount: _____

F. Office Email Address (required):_____

G. Practice Website Address (if any):_____

II. Certification Education Update

A. Are you currently board certified? ☐Yes ☐No Certified by American Board of:_____

Specialty:_____ Date Certified:_____Expiration Date: _____

Secondary Board Certification:_____ Date Certified:_____Expiration Date: _____

B. Medical School:_____Month/Year of Graduation:_____

C. SC Professional License Number Where Currently in Practice:_____

Additional Professional License Number: _____

Additional Professional License Number: _____

Additional Professional License Number: _____

We thank you for being a part of our networks. Although we will do everything to ensure there are no delays, the recredentialing process may take up to 120 days after receipt of the completed application to verify, review and obtain final approval.

As a practitioner undergoing the recredentialing process, it's important to know that you have specific rights designed to ensure transparency, fairness, and due process throughout the evaluation. Below is a summary of your rights during the recredentialing process:

1. You have the right to review information obtained from outside sources (e.g., state licensing boards) used to evaluate your recredentialing application. Note: *This does not include references, recommendations, or other peer-review protected information.*
2. You have the right to correct any erroneous information submitted by outside sources. If credentialing staff identify a discrepancy or cannot verify submitted information, they will notify you in writing. This notification will include:
    - The specific erroneous information
    - Instructions on how to correct it (format and submission process).
    - Where to send your corrections.
    - Timeframe for submitting corrections (21 days).

    Corrections must be submitted within 21 days of the date of the notification. We will document receipt of your corrected information in your recredentialing file.
3. You have the right to be informed of the status of your recredentialing application upon request. When requested, we will respond by phone or email within 7 calendar days and will include:
    - The date your completed application was received.
    - Any outstanding items needed for completion.
    - The expected date of the recredentialing decision.

Note: To exercise the above rights, please fax your inquiries to 803-870-9997.

You will be notified of the Credentialing Committee's or Medical Director's review decision via email within 10 calendar days of the determination.
We do not base recredentialing decisions on an applicant's race, ethnic/national identity, gender, age, sexual orientation or patient's insurance coverage in which the practitioner specializes.

III. Please answer the following questions (This section must be completed by the practitioner.):

Managed Care Organizations must have updated liability 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?	☐ Yes	☐ No
2. In the past three years have you been convicted of a felony?	☐ Yes	☐ No
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?	☐ Yes	☐ No
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 areas of practice, or Unable to perform those essential functions without a direct threat to the health and safety of others?	☐ Yes	☐ No
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?	☐ Yes	☐ No
6. In the past three years have you been publicly reprimanded or disciplined by a professional Licensing agency or board?	☐ Yes	☐ No
7. In the past three years has your DEA certification or state-controlled drug permit been restricted, Suspended, revoked, voluntarily relinquished or otherwise limited?	☐ Yes	☐ No
8. In the past three years have any of your privileges or memberships at any hospital or institution Been denied, suspended, reduced, revoked, not renewed or otherwise limited?	☐ Yes	☐ No
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?	☐ Yes	☐ No
10. In the past three years has your participation in an Insurance Company network been limited or Terminated?	☐Yes	☐No
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?	☐Yes	☐No
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?	☐Yes	☐No
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?	☐Yes	☐No
14. In the past three years has your professional liability insurer placed conditions or restrictions on your coverage or ability to get coverage?	☐Yes	☐No

(the above information will be held strictly Confidential)

Signature:_____ Date:_____

Please Print Name:_____

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-credentialed 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 with- out 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 curtailment or participating status, membership and/or privileges of any type to or from the Managed Care Organization.

If I am re-credentialed 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 Contact Person: _____	Office #1 Phone: _____ Office #1 Fax: _____ Tax ID (if different): _____
Satellite Office #2 Address: _____ _____ Office Contact Person: _____	Office #2 Phone: _____ Office #2 Fax: _____ Tax ID (if different): _____
Satellite Office #3 Address: _____ _____ Office Contact Person: _____	Office #3 Phone: _____ Office #3 Fax: _____ Tax ID (if different): _____
Satellite Office #4 Address: _____ _____ Office Contact Person: _____	Office #4 Phone: _____ Office #4 Fax: _____ Tax ID (if different): _____
Satellite Office #5 Address: _____ _____ Office Contact Person: _____	Office #5 Phone: _____ Office #5 Fax: _____ Tax ID (if different): _____
Satellite Office #6 Address: _____ _____ Office Contact Person: _____	Office #6 Phone: _____ Office #6 Fax: _____ Tax ID (if different): _____

Attestation of Hospital Privileges

a. Hospital Staff Privileges

Hospital Name	City/State	Statute of privileges: (Active, Courtesy, Consulting, etc.) *"Pending" or "Applied for" Are Not Acceptable*	Percentage of inpatient admissions

Are your hospital privileges active and in good standing? ☐Yes ☐No

If you do not admit, please describe arrangements to provide hospital care: _____

VI. 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.