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

Health Professional Application to File Claims

For in-state, out-of-network providers

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 and BlueChoice HealthPlan for:

- Preferred Blue (PPC and FEP)
- State Health Plan
- Medicare Advantage
- Blue Essentials
- Blue Option℠
- Healthy Blue℠
- BlueChoice HealthPlan

Please include a copy of the National Plan and Provider Enumeration System (NPPES) NPI notification with this application.

Note: Do not file claims to BlueCross with your NPI at this time. Continue to file claims with your BlueCross provider numbers only. Fax the completed form and appropriate documentation to 803-264-4795 or email Provider.Blue.Updates@bcbssc.com.

If you have any questions, email Provider.Blue.Questions@bcbssc.com. If you want BlueCross or BlueChoice to pay 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.**

Name: _____ Date of Request: _____

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):

_____
(Street)

_____ _____
(City) (State)

_____ _____
(ZIP) (County)

Mailing Address (Pay to Address):

_____
(P.O. Box or Street)

_____ _____
(City) (State)

_____ _____
(ZIP) (County)

Additional Practice Locations

(Name)	(Tax ID Number)	(NPI)
(Name)	(Tax ID Number)	(NPI)
(Name)	(Tax ID Number)	(NPI)

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License Number: _____ ☐ Temporary Limited ☐ Permanent Language(s): _____

Issuing State: _____ Effective Date: _____

Medicare uPIN Number: _____ DEA Number: _____

Primary Specialty: _____ Board Certification Date: _____

Secondary Specialty: _____ Board Certification Date: _____

Medical School Graduated: _____ Date: _____ (MM/YYYY)

University Graduated: _____ Date: _____ (MM/YYYY)

Highest Degree: _____ Date: _____ (MM/YYYY)

Please give the date you began performing services for payment outside the scope of an intern or training program, after you completed your residency: _____.

Signature of Practitioner: _____

Email Address (required for notification): _____

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