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

Registration Form for Midlevel and Hospital-Based Providers

Note: If you are being credentialed for Healthy Blue℠, please complete the Provider Enrollment Application.

Email the completed form and required documents to Provider.Blue.Enroll@bcbssc.com or fax to 803-870-8919.

First Name:	Last Name:	Middle Initial:	Title: (DO, MD, CRNA, NP, PA)
SSN:	NPI Number:	Medicare Number:	
Date of Birth:	Male ☐ Female ☐	Language(s) spoken:	
Race (optional):	Ethnicity (optional):		
Practitioner Type: ☐ Radiologist ☐ Emergency Medicine ☐ Pathologist ☐ Anesthesiologist ☐ Hospitalist ☐ CRNA ☐ Nurse Practitioner ☐ Physician Assistant			
SC License/Registration Number:	DEA Certificate Number *(if applicable):*		
Hospital Affiliations *(if applicable):* *Note: If more than one, please indicate the primary affiliation.*			
Accepting New Patients: ☐ Yes ☐ No	Age Limitations: Min Age _____ Max Age _____	Gender Restrictions: ☐ M ☐ F ☐ Both	
Board Certification: Primary Specialty: _____ Certifying Board: _____ Date Certified: _____ Expiration Date: _____ Secondary Specialty: _____ Certifying Board: _____ Date Certified: _____ Expiration Date: _____			
Malpractice Insurance Policyholder: ☐ Self ☐ Facility ☐ Other: _____			

Residency (MD and DO)	
Training Institution:	Residency Specialty:
Start Date (MM/YYYY):	Graduation Date (MM/YYYY):
City:	State:
County:	Program Completed: ☐ Yes ☐ No

Service Address Information	
Primary Service Address	**Additional Service Address**
Practice Name:	Practice Name:
Physical Address:	Physical Address:
Credentialing Contact's Name:	Credentialing Contact's Name:
Appointment Phone:	Appointment Phone:
Fax:	Fax:
Email **(Required)**:	Email **(Required)**:

Practice Information

Tax ID Number:	NPI (Group or Facility, if applicable):	Billing Contact's Name:	
Checks to Be Made Payable to:		Billing Phone Number:	Fax Number:
			Email **(Required)**:
Payment Address:			
Mailing Correspondence Address:			

Clinical Laboratory Improvement Amendment (CLIA)

Does the Provider/Facility bill for laboratory services in the office? ☐ Yes ☐ No ☐ N/A	Do you have a current CLIA certification? ☐ Yes ☐ No ☐ N/A	
CLIA Certification Number:	CLIA Certificate Effective Date:	CLIA Certificate Expiration Date:

Practitioner's Signature

Note: Application will not be processed without signature.

Signature:	Date: