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

Application for Clinic/Group/Institution/Location to: File Claims, Change Employer Identification Number (EIN), or Change NPI Number

Complete this form to notify BlueCross BlueShield of South Carolina and BlueChoice HealthPlan of the creation of a new location that wishes to file claims for the following networks. Check all that apply.

- ☐ Preferred Blue (PPC & FEP)
- ☐ BlueChoice HealthPlan
- ☐ Healthy Blue℠
- ☐ State Health Plan
- ☐ Blue Essentials℠
- ☐ Dental
- ☐ Medicare Advantage
- ☐ Blue Option℠
- ☐ Do not wish to participate in network

You must verify your EIN by submitting one of the following: **Letter 147C, CP 575 E or tax coupon 8109-C**.

Note: A W-9 form cannot be accepted.

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

For network provider requests, email the completed form and required documents to Provider.Blue.Enroll@bcbssc.com or fax to 803-870-8919. For non-network requests, email Provider.Blue.Updates@bcbssc.com or fax to 803-264-4795.

Note: This form does not qualify you to be a network provider.

Date of Request: _____

Name of Business (DBA): _____

Name of Business (Legal Business Name): _____

Earliest date of service for BlueCross/BlueChoice® claim for group: _____

NPI: _____ Federal Tax ID (EIN): _____

Previous NPI (If Applicable): _____ Previous Tax ID (If Applicable): _____

If new EIN is a result of a merger/acquisition? ☐ Yes ☐ No

Were assets and liabilities purchased? ☐ Assets only ☐ Assets and Liabilities

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Do you want this location to be shown in the provider directory? ☐ Yes ☐ No

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Note: All address types must be entered. You cannot use "same as" or leave any fields blank.

Practice/Institution Location Address		Payment Address		Correspondence Address	
Address:		Address:		Address:	
City:		City:		City:	
State:	ZIP:	State:	ZIP:	State:	ZIP:
County:		County:		County:	
Phone Number:		Phone Number:		Phone Number:	
Fax Number:		Fax Number:		Fax Number:	

Office Email Address: _____ Office Website: _____

Does the Provider/Facility bill for laboratory services in the office? ☐ Yes ☐ No ☐ N/A
N/A only applies to: DME, PT, ST, OT, NP, SLP and Dieticians.

Do you have a current CLIA certification? ☐ Yes ☐ No ☐ N/A
N/A only applies to: DME, PT, ST, OT, NP, SLP and Dieticians.

CLIA Certification ID Number: _____

CLIA Certificate Effective Date: _____ CLIA Certificate Expiration Date: _____

*****Attach a legible copy of your CLIA certificate.**

Office Hours:

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

Select the Type of Business:

- ☐ Alcohol/Sub. Abuse Institution
- ☐ College Infirmary
- ☐ Durable Medical Equipment
- ☐ General Acute Care Hospital
- ☐ Home Health Agency
- ☐ Hospice
- ☐ Independent Clinical Lab
- ☐ Orthotics/Prosthetics
- ☐ Outpatient Diagnostic Center
- ☐ Pharmacy Only
- ☐ Pharmacy with DME Sales
- ☐ Physiology Lab
- ☐ Portable X-ray Supplier
- ☐ Psychiatric Institution
- ☐ Rehabilitation Institution
- ☐ Rural Health Center Prof. Assoc./Clinic/Partnership
- ☐ Skilled Nursing Facility
- ☐ Other (Specify: _____

Select the Provider Type:

☐ Primary Care ☐ Specialist ☐ Hospitalist ☐ Other (Specify): _____

Provider Specialty: _____

Handicap Access? ☐ Yes ☐ No

All professional associations, corporations, partnerships, and clinics must complete this section:

Medicare Group Number: _____ Medicaid Group Number: _____

List each practitioner that will be providing services at this location:

Name:	Social Security #:	NPI:	Primary Specialty:
Name:	Social Security #:	NPI:	Primary Specialty:
Name:	Social Security #:	NPI:	Primary Specialty:
Name:	Social Security #:	NPI:	Primary Specialty:
Name:	Social Security #:	NPI:	Primary Specialty:
Name:	Social Security #:	NPI:	Primary Specialty:
Name:	Social Security #:	NPI:	Primary Specialty:
Name:	Social Security #:	NPI:	Primary Specialty:

All hospitals, institutions and other facilities must complete this section:

License Number: _____
Note: Attach copy of license.

Are you Joint Commission on Accreditation of Healthcare Organizations (JCAHO) accredited? ☐ Yes ☐ No
Note: Attach copy of accreditation.

Are you state certified? ☐ Yes ☐ No
Note: Attach copy of certification.

Are you cardiac rehabilitation certified? ☐ Yes ☐ No
Note: Attach copy of certification.

Medicare Certification Number: _____ Certification Date: _____
Note: Attach copy of Medicare certification.

Indicate the number of beds, excluding exempt units: _____

All ambulance services must complete this section:

The ambulance company bills all patients for rendered services. ☐ Yes ☐ No

The ambulance company is a voluntary ambulance company. ☐ Yes ☐ No

The ambulance company is a government-subsidized company. ☐ Yes ☐ No

Please check the appropriate boxes below.

I certify that the above-named ambulance company meets these requirements:

☐ Each of the company's ambulance vehicles is specially designed and equipped for emergency transportation of the sick or injured.

☐ The minimum ambulance crew consists of at least two members, one of whom must have a minimum training at least equivalent to that provided by the advanced Red Cross First Aid course.

☐ The ambulance company agrees to notify BlueCross/BlueChoice of any change in company ownership and/or operation which results in:

- The use of vehicles as ambulances which are not specially designed and equipped for emergency transportation of the sick or injured.
- The minimum first aid requirement for crew members is less than the advanced Red Cross First Aid course equivalent.
- The political jurisdiction in which the ambulance company is based requires a license to operate an ambulance service within the jurisdiction.

All applicants must complete this section:

Date legal entity established: _____

List each owner:

Name:	Title:	Social Security #:
Name:	Title:	Social Security #:
Name:	Title:	Social Security #:
Name:	Title:	Social Security #:
Name:	Title:	Social Security #:

Contact Person: _____ Contact Person's Phone Number: _____

Email Address: _____

Note: The email address is required for notification of when changes are complete. This can be for the contact person or office location.