



### Authorization for Clinic/Group to Bill for Services

Please complete this form to notify BlueCross BlueShield of South Carolina and BlueChoice HealthPlan that you have authorized a clinic/group/institution/location to bill for your services for:

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

Email the completed form and [required documents](#) to [Provider.Blue.Enroll@bcbssc.com](mailto:Provider.Blue.Enroll@bcbssc.com) or fax 803-870-8919.

BlueCross and BlueChoice HealthPlan reserve the right to accept or refuse authorization for a clinic/group/professional association/institution to bill for services.

**\*\*\*This form does not qualify you to be a network provider.**

Date of Request: \_\_\_\_\_

I agree that \_\_\_\_\_ (Name of Clinic, Group or Professional Association) will bill for and receive charges or fees for my services effective \_\_\_\_\_ (Date: MM/DD/YYYY).

EIN Number: \_\_\_\_\_

Please list all locations for this clinic, group, or professional association where this practitioner will be rendering services (if additional space is needed, please attach a list).

**Physical Address and NPI:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Signature of Practitioner

\_\_\_\_\_  
Practitioner's Name Printed

\_\_\_\_\_  
Practitioner's SSN and NPI

Do other clinics/groups/professional associations/institutions bill for your services?  Yes  No  
If yes, please list (Name and NPI):

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Signature & Title of Clinic/Group/Professional Association/Institution Representative

\_\_\_\_\_  
Representative's Contact Telephone Number

\_\_\_\_\_  
Email Address (required for notification)