

Application for Satellite Location

Please 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 Preferred Blue® (PPC), BlueChoice HealthPlan, BlueChoice HealthPlan Medicaid, the State Health Plan and/or FEP. If submitting an NPI, please include your confirmation letter from NPPES. Fax the completed form and appropriate documentation to 803-264-4795.

If you have questions about this form, you may send those questions to Provider.Cert@bcbsc.com. If the practitioner is changing addresses, he or she must complete the *Change of Address Form*. If a practitioner is leaving a clinic/group, he or she must complete a *Termination for Clinic/Group Billing*.

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

(Please type or print)

Date of Request: _____

Name of Business: _____

Federal Tax ID (EIN): _____ Effective Date: _____

Date Clinic/Group Open for Business: _____ Previous Tax ID, if applicable: _____

National Provider Identifier (NPI): _____ Previous Tax ID, if applicable: _____

Practice/Institution Location Address: _____ Payment Address: _____

County: _____ County: _____

Practice Appointment Phone #: _____ Practice Fax #: _____

Type of Business:

- | | | |
|--|---|---|
| <input type="checkbox"/> Professional Assoc/Clinic/Partnership | <input type="checkbox"/> Skilled Nursing Facility | <input type="checkbox"/> Independent Clinical Lab |
| <input type="checkbox"/> General Acute Care Hospital | <input type="checkbox"/> Home Health Agency | <input type="checkbox"/> Physiological Lab |
| <input type="checkbox"/> Rehabilitation Institution | <input type="checkbox"/> Hospice | <input type="checkbox"/> Portable X-Ray Supplier |
| <input type="checkbox"/> Psychiatric Institution | <input type="checkbox"/> Pharmacy Only | <input type="checkbox"/> Outpatient Diagnostic Ctr. |
| <input type="checkbox"/> Alcohol/Substance Abuse Institution | <input type="checkbox"/> Pharmacy with DME Sales | <input type="checkbox"/> Orthotics/Prosthetics |
| <input type="checkbox"/> Other (Specify) _____ | | |

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

Medicare Group #: _____

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

Name	Social Security #	NPI	Primary Specialty
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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

License #: _____ (attach copy of license)

Are you JCAHO accredited? No Yes (attach copy of accreditation)

Are you state certified? No Yes (attach copy of certification)

Are you cardiac rehabilitation certified? No Yes (attach copy of certification)

Member Certification #: _____ Certification Date: _____ (attach copy of Medicare certification)

Indicate the number of beds, excluding exempt units: _____

Contact Person: _____ Contact Person's Phone #: _____

Email Address (required for notification when we complete changes): _____

Enter text directly into the form by placing your cursor on each blank. Click on boxes to select them, or tab to them and press your spacebar. You can also save this form to your computer. Use the "Clear Form" button to delete all answers. Print the form and fax it to us to complete your application.