

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), BlueChoice HealthPlan, BlueChoice HealthPlan Medicaid, FEP and/or the State Health Plan. Fax the completed form to 803-264-4795. If you have questions, email Provider.Cert@bcssc.com.

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

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

(Please type or print)

Date of Request _____

I agree that _____ will bill for and receive charges or fees for my services
(Name of Clinic, Group or Professional Association)

effective _____
(Date: MMDDYYYY)

(Signature of Practitioner)

(Practitioner's Name Printed)

(Practitioner's Social Security Number)

(Practitioner's National Provider Identifier)

(Practitioner's License Number)

Clinic/Group/Professional Association/Institution Physical Address:

Payment Address:

(Signature of Clinic/Group/Professional Association/Institution Representative)

(Title of Clinic/Group/Professional Association/Institution Representative)

(Representative's Contact Telephone Number)

Email Address (required for notification when we complete changes)

Enter text directly into this 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.

BlueCross BlueShield of South Carolina and BlueChoice HealthPlan are independent licensees of the Blue Cross and Blue Shield Association.