

Health Professional Application to File Claims

Complete this form to request the addition of a health professional to our database to enable that practitioner to file claims to BlueCross BlueShield of South Carolina and BlueChoice HealthPlan for Preferred Blue® (PPC), BlueChoice HealthPlan, BlueChoice HealthPlan Medicaid, the State Health Plan and/or FEP. **Please include a copy of the National Plan and Provider Enumeration System (NPES) NPI notification with this application.** Note: Do not file claims to BlueCross with your NPI at this time. Continue to file claims with your BlueCross provider numbers only. Fax the completed form and appropriate documentation to 803-264-4795.

If you have questions, email Provider.Cert@bcssc.com. If you want BlueCross or BlueChoice HealthPlan to pay a clinic, group, professional association or institution, please complete the *Authorization for Clinic/Group to Bill for Services* form.

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

(Please type or print)

Name: _____ Date of Request: _____

Social Security Number: _____ Date of Birth: _____

*Federal Tax ID Number: _____ Effective Date: _____

*National Provider Identifier (NPI): _____

Appointment Phone Number: _____ Fax Number: _____

***REQUIRED FIELDS**

ADDRESS (Physical Location):

MAILING ADDRESS (Pay to Address):

(Street)

(City) (State)

(ZIP) (County)

(P.O. Box or Street)

(City) (State)

(ZIP) (County)

ADDITIONAL PRACTICE LOCATIONS:

_____ (Name)	_____ (Tax ID Number)	_____ (NPI)
_____ (Name)	_____ (Tax ID Number)	_____ (NPI)
_____ (Name)	_____ (Tax ID Number)	_____ (NPI)

License Number: _____ Temporary Limited Permanent Language(s): _____

Issuing State: _____ Effective Date: _____

Medicare UPIN Number: _____ DEA Number: _____

Primary Specialty: _____ Board Certification Date: _____

Secondary Specialty: _____ Board Certification Date: _____

Medical School Graduated: _____ Year: _____

University Graduated: _____ Year: _____

Highest Degree: _____ Year: _____

Please give the date you began performing services for payment outside the scope of an intern or training program, after you completed your residency: _____

SIGNATURE OF PRACTITIONER: _____ EMAIL ADDRESS: _____
(required for notification when we complete changes)