

APPENDIX D
BLUECHOICE HEALTHPLAN OF SOUTH CAROLINA, INC.
ADDITION OF PHYSICIAN

PRACTICE/GROUP NAME: _____

FEDERAL TAX ID NUMBER: _____

PRACTICE/GROUP NPI NUMBER: _____

PHYSICIAN'S NAME: _____

SOCIAL SECURITY NUMBER: _____

PHYSICIAN NPI NUMBER: _____

I have joined the above group/practice which has an existing Professional Agreement with BlueChoice HealthPlan of South Carolina, Inc. I request that my name be added as a member of said group. I agree to all of the terms of the existing Professional Agreement between said group and BlueChoice HealthPlan of South Carolina, Inc. I also agree to sign a Hold Harmless Agreement as required by the South Carolina Insurance Department.

Physician

BlueChoice HealthPlan of South Carolina, Inc.

Date

Date