BlueCross BlueShield of South Carolina and
BlueChoice® HealthPlan of South Carolina

Application for Clinic/Group/Institution/Location to: File Claims, Change Employer Identification Number (EIN), or Change NPI Number

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 the following networks. Check all that apply.

- ☐ Preferred Blue (PPC & FEP)
- ☐ BlueChoice HealthPlan
- ☐ Healthy Blue℠
- ☐ State Health Plan
- ☐ Blue Essentials℠
- ☐ Dental
- ☐ Medicare Advantage
- ☐ Blue Option℠
- ☐ Do not wish to participate in network

You must verify your EIN by submitting one of the following: **Letter 147C, CP 575 E or tax coupon 8109-C**.

Note: A W-9 form cannot be accepted.

Please include a copy of the National Plan and Provider Enumeration System (NPPES) National Provider Identifier (NPI) notification with this form.

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

Date of Request: _____

Name of Business (DBA): _____

Name of Business (Legal Business Name): _____

Earliest date of service for BlueCross/BlueChoice® claim for group: _____

NPI: _____ Federal Tax ID (EIN): _____

Previous NPI (If Applicable): _____ Previous Tax ID (If Applicable): _____

If new EIN is a result of a merger/acquisition? ☐ Yes ☐ No

Were assets and liabilities purchased? ☐ Assets only ☐ Assets and Liabilities

Revised 06/2023

Do you want this location to be shown in the provider directory? ☐ Yes ☐ No

---

Note: All address types must be entered. You cannot use "same as" or leave any fields blank.

Practice/Institution Location Address		Payment Address		Correspondence Address	
Address:		Address:		Address:	
City:		City:		City:	
State:	ZIP:	State:	ZIP:	State:	ZIP:
County:		County:		County:	
Phone Number:		Phone Number:		Phone Number:	
Fax Number:		Fax Number:		Fax Number:	

Office Email Address: _____ Office Website: _____

Does the Provider/Facility bill for laboratory services in the office? ☐ Yes ☐ No ☐ N/A
N/A only applies to: DME, PT, ST, OT, NP, SLP and Dieticians.

Do you have a current CLIA certification? ☐ Yes ☐ No ☐ N/A
N/A only applies to: DME, PT, ST, OT, NP, SLP and Dieticians.

CLIA Certification ID Number: _____

CLIA Certificate Effective Date: _____ CLIA Certificate Expiration Date: _____

*****Attach a legible copy of your CLIA certificate.**

Electronic Claims Filing Requirement

To qualify for network participation, your practice must file a minimum of 90% of claims in a HIPAA-compliant electronic format. Can your practice meet this requirement? ☐ Yes ☐ No

---

Office Hours:

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

Select the Type of Business:

- ☐ Alcohol/Sub. Abuse Institution
- ☐ College Infirmary
- ☐ Durable Medical Equipment
- ☐ General Acute Care Hospital
- ☐ Home Health Agency
- ☐ Hospice
- ☐ Independent Clinical Lab
- ☐ Orthotics/Prosthetics
- ☐ Outpatient Diagnostic Center
- ☐ Pharmacy Only
- ☐ Pharmacy with DME Sales
- ☐ Physiology Lab
- ☐ Portable X-ray Supplier
- ☐ Psychiatric Institution
- ☐ Rehabilitation Institution
- ☐ Rural Health Center Prof. Assoc./Clinic/Partnership
- ☐ Skilled Nursing Facility
- ☐ Other (Specify: _____

Select the Provider Type:

☐ Primary Care ☐ Specialist ☐ Hospitalist ☐ Other (Specify): _____

Provider Specialty: _____

Handicap Access? ☐ Yes ☐ No

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

Medicare Group Number: _____ Medicaid Group Number: _____

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

Name:	Social Security #:	NPI:	Primary Specialty:
Name:	Social Security #:	NPI:	Primary Specialty:
Name:	Social Security #:	NPI:	Primary Specialty:
Name:	Social Security #:	NPI:	Primary Specialty:
Name:	Social Security #:	NPI:	Primary Specialty:
Name:	Social Security #:	NPI:	Primary Specialty:
Name:	Social Security #:	NPI:	Primary Specialty:
Name:	Social Security #:	NPI:	Primary Specialty:

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

License Number: _____
Note: Attach copy of license.

Are you Joint Commission on Accreditation of Healthcare Organizations (JCAHO) accredited? ☐ Yes ☐ No
Note: Attach copy of accreditation.

Are you state certified? ☐ Yes ☐ No
Note: Attach copy of certification.

Are you cardiac rehabilitation certified? ☐ Yes ☐ No
Note: Attach copy of certification.

Medicare Certification Number: _____ Certification Date: _____
Note: Attach copy of Medicare certification.

Indicate the number of beds, excluding exempt units: _____

All ambulance services must complete this section:

The ambulance company bills all patients for rendered services. ☐ Yes ☐ No

The ambulance company is a voluntary ambulance company. ☐ Yes ☐ No

The ambulance company is a government-subsidized company. ☐ Yes ☐ No

Please check the appropriate boxes below.

I certify that the above-named ambulance company meets these requirements:

☐ Each of the company's ambulance vehicles is specially designed and equipped for emergency transportation of the sick or injured.

☐ The minimum ambulance crew consists of at least two members, one of whom must have a minimum training at least equivalent to that provided by the advanced Red Cross First Aid course.

☐ The ambulance company agrees to notify BlueCross/BlueChoice of any change in company ownership and/or operation which results in:

- The use of vehicles as ambulances which are not specially designed and equipped for emergency transportation of the sick or injured.
- The minimum first aid requirement for crew members is less than the advanced Red Cross First Aid course equivalent.
- The political jurisdiction in which the ambulance company is based requires a license to operate an ambulance service within the jurisdiction.

All applicants must complete this section:

Date legal entity established: _____

List each owner:

Name:	Title:	Social Security #:
Name:	Title:	Social Security #:
Name:	Title:	Social Security #:
Name:	Title:	Social Security #:
Name:	Title:	Social Security #:

Contact Person: _____ Contact Person's Phone Number: _____

Email Address: _____

Note: The email address is required for notification of when changes are complete. This can be for the contact person or office location.