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

Application for Satellite Location

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 and FEP)
- ☐ State Health Plan
- ☐ Medicare Advantage
- ☐ Blue Essentials℠
- ☐ Blue Option℠
- ☐ Healthy Blue℠
- ☐ BlueChoice HealthPlan
- ☐ Dental
- ☐ 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

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

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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.**

Office Hours:

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

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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 ☐ Prof. Assoc./Clinic/Partnership ☐ Psychiatric Institution ☐ Rehabilitation Institution

☐ Rural Health Center ☐ 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: ____________

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.