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

Provider Enrollment Application

Complete this application and submit it along with the required documentation.

Please select which networks you wish to join:

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

Credentialing Contact Information:

Credentialing Contact's Name: _____

Credentialing Contact's Email: _____

Credentialing Contact's Phone: _____

Preferred Method of Contact: _____

PROVIDER ENROLLMENT APPLICATION

Your application will be considered in process when all fields on this application are completed and all required documentation is included. For a complete list of attachments please see the Provider Checklist coversheet.

Submit completed applications to Provider.Blue.Enroll@bcbssc.com or fax to 803-870-8919.

Note that all pages require provider initials and date.

1. APPLICANT INFORMATION

Last Name:	First Name:	Middle Initial:	Suffix:
Maiden Name:	Gender (optional): ☐ M ☐ F	Race (optional):	Ethnicity (optional):
Professional Designation:			
Social Security #:	National Provider ID#:	Birth Date (MM/DD/YY):	
Provider Email Address:	ECFMG # (if applicable):		
What date will this provider start working for your practice (MM/DD/YY):			

Language(s) Spoken (other than English) ☐ None

1.	2.	3.

Area(s) of Specialty

Primary:	Primary Taxonomy:	Sub-specialty:
Under which specialty do you wish to be listed in the provider directory?		
Provider Type: ☐ Primary Care ☐ Specialist ☐ Hospitalist ☐ Non-Physician Provider		
If family practitioner, do you offer OB care? ☐ Yes ☐ No ☐ N/A		

2. MEDICAL/PROFESSIONAL EDUCATION

Name of School:	Degree Received:	Start Date (MM/YY): Graduation Date:
City:	State:	Country:
Name of School:	Degree Received:	Start Date (MM/YY): Graduation Date:
City:	State:	Country:

3. PROFESSIONAL TRAINING

Internship/Residency/Fellowship/Post Graduate Professional Training/Other

Have you had Cultural Competency Training? ☐ Yes ☐ No Date Completed:

☐ Check here if entire section below is not applicable to Provider. **List all, completed or not.**

Training Institution:	Program: ☐ Internship ☐ Residency ☐ Fellowship ☐ Post Grad Training ☐Other: ___________________________________	
City:	State:	Country:
Program Completed: ☐ Yes ☐ No	Start Date (MM/YY):	Completion Date (MM/YY):
Training Institution:	Program: ☐ Internship ☐ Residency ☐ Fellowship ☐ Post Grad Training ☐Other: ___________________________________	
City:	State:	Country:
Program Completed: ☐ Yes ☐ No	Start Date (MM/YY):	Completion Date (MM/YY):
Training Institution:	Program: ☐ Internship ☐ Residency ☐ Fellowship ☐ Post Grad Training ☐Other: ___________________________________	
City:	State:	Country:
Program Completed: ☐ Yes ☐ No	Start Date (MM/YY):	Completion Date (MM/YY):

Provider Initials: _____________ Date: ______________________ (MM/DD/YY)

4. STATE LICENSE(S): List <u>all</u> current and past professional licenses

State	License #	Issue Date (MM/YY)	Expiration Date (MM/YY)	Status (Please check)
South Carolina				☐ Active ☐ Inactive
				☐ Active ☐ Inactive
				☐ Active ☐ Inactive
				☐ Active ☐ Inactive
				☐ Active ☐ Inactive
				☐ Active ☐ Inactive

5. SPECIALTY BOARD CERTIFICATION

☐ Check here if entire section is not applicable.

Are you board certified? ☐ Yes ☐ No (If yes, list below)

Certifying Board Name	Specialty	Initial Certification Date	Most Recent Recertification Date	Next Expiration Date

If not certified, are you qualified to sit for the examination?	☐ Yes ☐ No Date:

6. HOSPITAL PRIVILEGES

Do you have privileges at any hospital facility? ☐ Yes ☐ No

If no, please describe arrangements for hospital care:

Hospital:		Department:	
Street:	City:	State:	Zip code:
Status of Privileges:	Affiliation date (MM/YY) From: ______	Affiliation date (MM/YY) To: ______	% Admissions:
Hospital:		Department:	
Street:	City:	State:	Zip code:
Status of Privileges:	Affiliation date (MM/YY) From: ______	Affiliation date (MM/YY) To: ______	% Admissions:
Hospital:		Department:	
Street:	City:	State:	Zip code:
Status of Privileges:	Affiliation date (MM/YY) From: ______	Affiliation date (MM/YY) To: ______	% Admissions:
Hospital:		Department:	
Street:	City:	State:	Zip code:
Status of Privileges:	Affiliation date (MM/YY) From: ______	Affiliation date (MM/YY) To: ______	% Admissions:

Provider Initials: _____________ Date: ______________________ (MM/DD/YY)

7. WORK HISTORY (CV cannot be used in lieu of completing this section)

List your employer and dates of employment for the past five years.

Required: Provide explanation for any gaps of six months or more.

Name of Previous/ Current Employer	Date of Employment (MM/YY) **If still employed indicate "Present" in the first To: box**	
Current: _____	From:	To:
	From:	To:
	From:	To:
	From:	To:
	From:	To:
	From:	To:
	From:	To:
	From:	To:
	From:	To:
	From:	To:
	From:	To:
	From:	To:
	From:	To:
	From:	To:
	From:	To:

Provider Initials: _____ Date: _____ (MM/DD/YY)

8. OFFICE PRACTICE INFORMATION - PRIMARY SITE

Office practice name:			
Office e-mail:		Practice Website:	
Physical Office Location (address) Should the Provider display in the Directory at this location? ☐ Yes ☐ No			
Street:	City:	State:	Zip code:
Appointment Phone:	Fax Number:	County:	
Office Contact Person:	Phone #:	Email:	
Credentialing Contact:	Phone #:	Email:	
Group EIN/TIN #:	Group NPI #:		
Group Medicare #:	Has your group signed agreement to participate with Medicare in the past twelve months? ☐ Yes ☐ No		

Clinical Laboratory Improvement Amendment (CLIA)

Note: If you are CLIA certified, please submit a copy of the certification.

Does the Provider/Facility bill for laboratory services in the office? ☐ Yes ☐ No ☐ N/A	Do you have a current CLIA certification? ☐ Yes ☐ No ☐ N/A	
CLIA Certification Number:	CLIA Certificate Effective Date:	CLIA Certificate Expiration Date:

Office Hours

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
AM:	AM:	AM:	AM:	AM:	AM:	AM:
PM:	PM:	PM:	PM:	PM:	PM:	PM:

After hours phone number:	Handicap access: ☐ Yes ☐ No
Is your office equipped with telecommunication devices for the deaf? ☐ Yes ☐ No	Does your office offer 24/7 coverage? ☐ Yes ☐ No Please describe:
Is sign language assistance available? ☐ Yes ☐ No	Languages spoken by staff:

Billing Address ☐ Same as Office Location

Name claims payable to:			
Street/PO:	City:	State:	Zip code:
Phone #:	Fax #:		

Mailing Address ☐ Same as Office Location

Street/PO:	City:	State:	Zip code:
Phone #:	Fax #:		

PROVIDER PATIENT POPULATION

Does this provider see patients at this location? ☐ Yes ☐ No	If yes, do they accept new patients at this location? ☐ Yes ☐ No	
Individual Medicaid #:	Do you accept Medicaid patients? ☐ Yes ☐ No	
Are there patient age limitations? ☐ Yes ☐ No	Minimum Age:	Maximum Age:
Are there patient gender restrictions? ☐ Yes ☐ No	Males Only: ☐	Females Only: ☐
Please describe any other patient limitations:		

Provider Initials: _____ Date: _____ (MM/DD/YY)

9. ADDITIONAL OFFICE SITE - ☐ Check here if not applicable

For each additional location duplicate this page.

Office practice name:			
Office e-mail:	Practice Website:		
Physical Office Location (address) Should the Provider display in the Directory at this location? ☐ Yes ☐ No			
Street:	City:	State:	Zip code:
Appointment Phone:	Fax Number:	County:	
Office Contact Person:	Phone #:	Email:	
Credentialing Contact:	Phone #:	Email:	
Group EIN/TIN #:	Group NPI #:		

Clinical Laboratory Improvement Amendment (CLIA)

Note: If you are CLIA certified, please submit a copy of the certification.

Does the Provider/Facility bill for laboratory services in the office? ☐ Yes ☐ No ☐ N/A	Do you have a current CLIA certification? ☐ Yes ☐ No ☐ N/A	
CLIA Certification Number:	CLIA Certificate Effective Date:	CLIA Certificate Expiration Date:

Office Hours

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
AM:	AM:	AM:	AM:	AM:	AM:	AM:
PM:	PM:	PM:	PM:	PM:	PM:	PM:

After hours phone number:	Handicap access: ☐ Yes ☐ No
Is your office equipped with telecommunication devices for the deaf? ☐ Yes ☐ No	Does your office offer 24/7 coverage? ☐ Yes ☐ No Please describe:
Is sign language assistance available? ☐ Yes ☐ No	Languages spoken by staff:

Billing Address ☐ Same as Office Location

Name claims payable to:			
Street/PO:	City:	State:	Zip code:
Phone #:	Fax #:		

Mailing Address ☐ Same as Office Location

Street/PO:	City:	State:	Zip code:
Phone #:	Fax #:		

PROVIDER PATIENT POPULATION

Does this provider see patients at this location? ☐ Yes ☐ No	If yes, do they accept new patients at this location? ☐ Yes ☐ No	
Do you accept Medicaid patients at this location? ☐ Yes ☐ No		
Are there patient age limitations? ☐ Yes ☐ No	Minimum Age:	Maximum Age:
Are there patient gender restrictions? ☐ Yes ☐ No	Males Only: ☐	Females Only: ☐
Please describe any other patient limitations:		

Provider Initials: _____ Date: _____ (MM/DD/YY)

10. PROVIDER DISCLOSURE INFORMATION (This section must be completed by Provider.)

If you answer yes to any of the questions listed below, include a detailed explanation of each answer on the following page. The explanation must accompany the application for it to be considered a complete application.

PROVIDER NAME:

1.	Do you have any pending misdemeanor or felony charges?	☐ Yes	☐ No
2.	Have you ever been convicted of a felony?	☐ Yes	☐ No
3.	Has your license to practice medicine in any jurisdiction ever been voluntarily or involuntarily denied, restricted, suspended, challenged, revoked, conditioned or otherwise limited?	☐ Yes	☐ No
4.	In the past five years and up to and including the present, have you had any ongoing physical or mental impairment or condition which would make you unable, with or without reasonable accommodation, to perform the essential functions of a practitioner in your area of practice, or unable to perform those essential functions without a direct threat to the health and safety of others?	☐ Yes	☐ No
5.	Considering the essential functions of a practitioner in your area of practice is the past five years and up to and including the present, have you suffered from any communicable health condition that could pose a significant health and safety risk to your patients?	☐ Yes	☐ No
6.	Have you ever been publicly reprimanded or disciplined by a professional licensing agency or board?	☐ Yes	☐ No
7.	Has your DEA certification or state-controlled drug permit ever been restricted, suspended, revoked, voluntarily relinquished or otherwise limited?	☐ Yes	☐ No
8.	Have any of your privileges or memberships at any hospital or institution ever been denied, suspended, reduced, revoked, not renewed, or otherwise limited?	☐ Yes	☐ No
9.	Has your participation in Medicare, Medicaid, or any other government program ever been limited, curtailed or have you voluntarily excluded yourself from any of these programs?	☐ Yes	☐ No
10.	Has your participation in an Insurance Company network ever been limited or terminated?	☐ Yes	☐ No
11.	In the past five year and up to the present, have you had a history of chemical dependency or substance abuse that might affect your ability to competently and safely perform the essential functions of a practitioner in your area of practice?	☐ Yes	☐ No
12.	In the past five years and up to and including the present, have you had or do you have any mental or physical condition or do you take any medications that might affect your ability to competently and safely perform the essential functions of a practitioner in your area of practice?	☐ Yes	☐ No
13.	Has any malpractice carrier ever made an out-of-court settlement or paid a judgement of a medical malpractice claim on your behalf or are any medical malpractice suits pending against you?	☐ Yes	☐ No
14.	Has your professional liability insurer ever placed conditions or restrictions on your coverage or ability to obtain coverage?	☐ Yes	☐ No

NOTE: IF YES TO ANY OF THE ABOVE, EXPLAIN ON THE FOLLOWING PAGE. THIS INFORMATION WILL BE HELD CONFIDENTIAL.

Provider Initials: _____ Date: _____ (MM/DD/YY)

Check here if this page was intentionally left blank. ☐

PLEASE USE THIS PAGE FOR ANY QUESTIONS THAT YOU ANSWERED YES TO ON THE ABOVE PAGE.
Prewritten explanations may be attached in lieu of a written explanation below.

Provider Initials: _____ Date: _____ (MM/DD/YY)

Revised 06/2023

11. AUTHORIZATION

I CERTIFY THAT ALL INFORMATION CONTAINED IN THIS APPLICATION AND ALL ITS ATTACHMENTS ARE ACCURATE, COMPLETE AND TRUE.

I understand that:

A. Any misrepresentation, misstatement, or omission of a relevant fact in connection with this application may result in denial of my application or termination of my participation in the Managed CareOrganization;

B. It is my responsibility to promptly advise the Managed Care Organization in writing within 30 days of any changes or additions to the information contained in thisapplication;

C. All the information contained in this application, or its attachments, is subject to the Managed Care Organization's investigation and review and;

D. This is an application only and my submission of this application does not automatically result in participation with the Managed Care Organization.

NOTICE: The National Practitioner Data Bank will be queried if you apply. If your application is rejected for reasons relating to professional conduct or professional competence, which reasons include misrepresenting, misstating, or omitting a relevant fact in connection with your application, the rejection may be reported to The National Practitioner Data Bank.

I authorize the Managed Care Organization to consult with administrators and members of the medical staffs of hospitals or institutions with which I have been or am currently associated, and with others, including without limit past and present malpractice carriers, who may have information bearing on my professional competence, character and ethical qualifications. I further consent to the inspection by agents, employees, contractors, affiliates, or other representatives of the Managed Care Organization of all documents that may be material to an evaluation of my professional competence, character, and ethical qualifications.

I release from liability the Managed Care Organization and all representatives of the Managed Care Organization for their acts performed in good faith and without malice or negligence in connection with evaluating my application and my credentials and qualifications, and I release from any liability any and all individuals and organizations who provide information to the Managed Care Organization in good faith and without malice or negligence concerning my professional competence, character and ethics. I consent to the release and exchange of information as allowed by law relating to any application, investigation, disciplinary action, suspension, or curtailment of participation status, membership and/or privileges of any type to or from the Managed Care Organization.

NAME: _____
(Applicant Name, print or type)

SIGNATURE: _____ DATE: _____ (MM/DD/YY)
(Applicant)

EACH SUBMISSION REQUIRES AN ORIGINAL SIGNATURE AND CURRENT DATE.

Provider Initials: _____ Date: _____ (MM/DD/YY)

Providers have the right to:

1. Review information submitted to support the credentialing application
2. Correct erroneous information
3. Be informed of the status of the credentialing application

Providers will hear from us:

1. Submission of application
2. If application is incomplete or moving onto the onboarding status
3. During any delays
4. Once the provider is credentialed

Note: To exercise the above rights, please email your inquiries to Provider.Credentialing@bcbssc.com.

Provider Initials: _____ Date: _____ (MM/DD/YY)