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

Authorization for Clinic/Group to Bill for Services

Please complete this form to notify BlueCross BlueShield of South Carolina and BlueChoice HealthPlan that you have authorized a clinic/group/institution/location to bill for your services for:

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

BlueCross and BlueChoice HealthPlan reserve the right to accept or refuse authorization for a clinic/group/professional association/institution to bill for services.

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

Date of Request: _____

I agree that _____ (Name of Clinic, Group or Professional Association) will bill for and receive charges or fees for my services effective _____ (Date: MM/DD/YYYY).

EIN Number: _____

Please list all locations for this clinic, group, or professional association where this practitioner will be rendering services (if additional space is needed, please attach a list).

Physical Address and NPI:

_____ _____

_____ _____

_____
Signature of Practitioner

_____
Practitioner's Name Printed

_____ _____
Practitioner's SSN and NPI

Do other clinics/groups/professional associations/institutions bill for your services? ☐ Yes ☐ No
If yes, please list (Name and NPI):

_____ _____

_____ _____

_____ _____
Signature & Title of Clinic/Group/Professional Association/Institution Representative

_____
Representative's Contact Telephone Number

_____
Email Address (required for notification)

BlueCross BlueShield of South Carolina and BlueChoice® HealthPlan are independent licensees of the Blue Cross and Blue Shield Association.
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