South Carolina

BlueChoice HealthPlan 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), FEP and/or the State Health Plan and BlueChoice HealthPlan. Fax the completed form to 803-264-4795. If you have questions, email Provider.Cert@bcbssc.com.

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

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

**(Please type or print)**

Date of Request_____

I agree that _____ will bill for and receive charges or fees for my services
(EIN and Name of Clinic, Group or Professional Association)

effective _____.
(Date: MMDDYYYY)

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

Physical Address/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 when we complete changes)

_____

Enter text directly into this form by placing your cursor on each blank. Click on boxes to select them, or tab to them and press your spacebar. You can also save this form to your computer. Use the "Clear Form" button on the right to delete all answers. Print the form and fax it to us to complete your application.