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

Please 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:

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

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

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

Email the completed form and required documents to Provider.Blue.Enroll@bcbssc.com or fax 803-870-8919.

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

Date of Request: _____

Name of Business: _____

Federal Tax ID (EIN):_____ Effective Date: _____

Earliest date of service for BlueCross/BlueChoice® claim for group:_____Previous Tax ID (If Applicable):_____

If new EIN is a result of a merger or acquisition, were the assets and liabilities purchased (Yesor No)? _____

NPI:_____ Old NPI (If Applicable): _____

Practice/Institution Location Address:	Payment Address:	Correspondence Address:
State: ZIP:	State: ZIP:	State: ZIP:
County:	County:	County:

Practice Appointment Phone #:_____ Practice Fax Number: _____

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Select the Type of Business:

____Professional Assoc/Clinic/Partnership
____Skilled Nursing FacilityI
____Independent Clinical Lab
____General Acute Care Hospital
____Rehabilitation Institution
____Psychiatric Institution
____Home Health Agency
____Hospice
____Pharmacy Only
____Physiological Lab
____Portable X-Ray Supplier
____Outpatient Diagnostic Center
____Alcohol/Substance Abuse Institution
____DME
____Pharmacy with DME Sales
____College Infirmary
____Orthotics/Prosthetics
____Other (Specify):_____

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

Medicare Group Number: _____

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

Name	Social Security #	NPI	Primary Specialty

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

License number:_____(Attach copy of license.)

Are you Joint Commission on Accreditation of Healthcare Organizations (**JCAHO**) accredited? _____No _____Yes (Attach copy of accreditation.)

Are you state certified? ☐ No ☐ Yes (Attach copy of certification.)

Are you cardiac rehabilitation certified?_____No _____Yes (Attach copy of certification.)

Medicare Certification Number:_____Certification Date:_____(Attach copy of Medicare certification.)

Indicate the number of beds, excluding exempt units: _____

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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:
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 #

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

*Email Address: _____

*Required for notification when changes are complete.

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