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[SM]
- Healthy Blue[SM]
- BlueChoice HealthPlan

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

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____will bill for and receive charges or fees for my services
(Name of Clinic, Group or Professional Association)

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 needed, please attach 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 when we complete changes):____.

BlueCross BlueShield of South Carolina and BlueChoice HealthPlan are independent licensees of the Blue Cross and Blue Shield Association
(Revised 1/19)