

New Provider Application

To apply for participation in the Healthy Blue provider network, please complete this form.

Provider website: _____

What languages (including American Sign Language) are offered by your staff?

Have you completed cultural competency training? Yes No

Do your office, exam rooms and equipment accommodate people with physical disabilities? Yes No

Providers can be connected to more than one location. Please list all practice locations to which you are connected.

Note, if you are a primary care physician and would like members assigned to you at a location, please select yes. By selecting yes, membership will be assigned, and you will receive a *Gap in Care Report* for that location.

Practice name: _____ EIN #: _____

Address: _____

City, State and ZIP: _____

Phone: _____ Fax: _____

Office contact: _____

Does this provider want members assigned to him/her at this location? Yes No

Practice name: _____ EIN #: _____

Address: _____

City, State and ZIP: _____

Phone: _____ Fax: _____

Office contact: _____

Does this provider want members assigned to him/her at this location? Yes No

www.HealthyBlueSC.com

Practice name: _____ EIN #: _____

Address: _____

City, State and ZIP: _____

Phone: _____ Fax: _____

Office contact: _____

Does this provider want members assigned to him/her at this location? Yes No

Practice name: _____ EIN #: _____

Address: _____

City, State and ZIP: _____

Phone: _____ Fax: _____

Office contact: _____

Does this provider want members assigned to him/her at this location? Yes No

Practice name: _____ EIN #: _____

Address: _____

City, State and ZIP: _____

Phone: _____ Fax: _____

Office contact: _____

Does this provider want members assigned to him/her at this location? Yes No

Email the completed form and [required documents](#) to Provider.Blue.Enroll@bcssc.com
or fax 803-870-8919.