

Request To Turn Off Paper Remits

TO BE COMPLETED BY PROVIDER

Request Type (circle one): Change Add Delete

Request Health Plan (mark "x" to indicate plan(s)): ___ BlueCross BlueShield of South Carolina ___ BlueChoice HealthPlan

Provider's Name

Address

City *State* *ZIP*

Contact's Name

Contact's Address

City *State* *ZIP*

Contact's Phone #

--

E-mail Address

--

Federal Tax ID

	-	
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(Base TIN)

(Three digit suffix<es> for location<s>, Example: -001,-002, -005)

In order to turn off paper remits, you must be set up for Electronic Funds Transfer (EFT).

Provider's Authorized Signature

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Printed Name

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Title

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Date

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Fax to: 803-264-4790