Application for Satellite Location

Please complete this form to notify BlueCross BlueShield of South Carolina and BlueChoice HealthPlan of the creation of a new location wanting to file claims for:

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

If submitting a National Provider Identifier (NPI), please include your confirmation letter from the National Plan and Provider Enumeration System (NPPES). Email the completed form and appropriate documentation to Provider.Blue.Updates@bcbssc.com or fax it to 803-264-4795.

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 (Yes or No)? _____

NPI:_____ Old NPI (If Applicable): _____

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

Practice's Appointment Phone #:_____ Practice's Fax #: _____

Type of Business:

_____Professional Assoc/Clinic/Partnership
_____General Acute Care Hospital
_____Rehabilitation Institution
_____Psychiatric Institution
_____Alcohol/Substance Abuse Institution
_____DME
_____Skilled Nursing Facility
_____Home Health Agency
_____Hospice
_____Pharmacy Only
_____Pharmacy with DME Sales
_____Orthotics/Prosthetics
_____Independent Clinical Lab
_____Physiological Lab
_____Portable X-Ray Supplier
_____Outpatient Diagnostic Ctr.
_____College Infirmary

_____Other (Specify): _____

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

Medicare Group Number: _____

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

Name	Social Security #	NPI	Primary Specialty
Name	Social Security #	NPI	Primary Specialty
Name	Social Security #	NPI	Primary Specialty
Name	Social Security #	NPI	Primary Specialty
Name	Social Security #	NPI	Primary Specialty
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: _____

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

*Email Address: _____

*Required for notification when changes are complete.