



# BlueCross BlueShield of South Carolina and BlueChoice® HealthPlan of South Carolina

## Provider Enrollment Application

Please complete this application and submit it along with the other required documentation to [Provider.Blue.Enroll@bcssc.com](mailto:Provider.Blue.Enroll@bcssc.com)

Please select which networks you wish to join:

Preferred Blue (PPC and FEP)

Blue Option<sup>SM</sup>

State Health Plan

Healthy Blue<sup>SM</sup>

Medicare Advantage

BlueChoice HealthPlan

Blue Essentials

Credentialing Contact Information:

Credentialing Contact's Name: \_\_\_\_\_

Credentialing Contact's Email: \_\_\_\_\_

Credentialing Contact's Phone: \_\_\_\_\_

Preferred Method of Contact: \_\_\_\_\_

# CHECKLIST FOR INITIAL PROVIDER ENROLLMENT

Submit all documentation to [Provider.Blue.Enroll@bcssc.com](mailto:Provider.Blue.Enroll@bcssc.com).

Use this checklist to determine which forms you need based on your specialty type. **Each checklist item is hyperlinked to forms or examples for your reference.** Note: Mid-levels include NP, PA, CRNA, CNM, CNS and hospital-based physicians. Ancillary includes speech, physical, occupational and audiology therapists.

	Checklist Items	Mid-Level	Physician	DDS	DMD	Ancillary	Chiro
A	<a href="#">Provider Enrollment Application</a>	See Footnote 1			See Footnote 7		
B	<a href="#">Registration Form for Mid-Level and Hospital-Based Providers</a>						
C	<a href="#">SC Dental Credentialing Application<sup>2</sup></a>						
D	<a href="#">Copy of SC Medical/Practice License</a>						
E	<a href="#">DEA Certification<sup>4</sup></a>			See Footnote 3	See Footnote 3		
F	<a href="#">Current Copy of Malpractice Insurance (Minimum \$1M/\$3M)</a> (Must include the provider's name or a roster with the provider name to be valid.)						
G	<a href="#">Authorization for Clinic/Group to Bill for Services<sup>5</sup></a>						
H	<a href="#">Clinical Lab Improvement Amendments (CLIA) Form</a>				See Footnote 7		
I	<a href="#">NP Preceptor Form</a>						
J	Network Contracts (send in a <a href="#">request</a> )						
K	<a href="#">Hold Harmless for BlueChoice HealthPlan</a>						
L	<a href="#">Appendix D for BlueChoice HealthPlan</a>						
<b>Additional Items for Medicaid</b>							
M	Medicaid ID Number <sup>6</sup>				See Footnote 7		
N	<a href="#">Nurse Protocols</a>						

<sup>1</sup>If you are a mid-level provider who wants to be enrolled in our Medicaid network, fill out the Provider Enrollment Application.

<sup>2</sup>If the provider performs any routine dental services, the Dental Credentialing Application is needed.

<sup>3</sup>If applicable.

<sup>4</sup>Required for M.D.s, D.O.s, O.D.s, N.P.s and P.A.s.

<sup>5</sup>A copy is included in the Provider Enrollment Application.

<sup>6</sup>On the Provider Enrollment Application.††

<sup>7</sup>Required when DMD is applying for medical networks.

# PROVIDER ENROLLMENT APPLICATION

Your application will be considered in process when all fields on this application are complete and all required documentation is included. For a complete list of attachments please see the Provider Checklist coversheet.

Submit completed applications to **Provider.Blue.Enroll@bcbssc.com** or fax 803-870-8919

Note that all pages require provider initials and date.

## 1. APPLICANT INFORMATION

Last Name:	First Name:	Middle Initial:	Suffix:
Maiden Name:	Gender(optional): <input type="checkbox"/> Male <input type="checkbox"/> Female	Professional Designation:	
Social Security #:	National Provider ID#:	Birth Date (MM/DD/YY):	
Provider Email Address:		ECFMG # (if applicable):	
What date will this provider start working for your practice (MM/DD/YY):			

Language(s) Spoken (other than English)  None

1.	2.	3.
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### Area(s) of Specialty

Primary:	Primary Taxonomy:	Sub-specialty:
Under which specialty do you wish to be listed in the provider directory?:		
Provider Type: <input type="checkbox"/> Primary Care <input type="checkbox"/> Specialist <input type="checkbox"/> Hospitalist <input type="checkbox"/> Non-Physician Provider		
If family practitioner, do you offer OB care? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A		

## 2. MEDICAL/PROFESSIONAL EDUCATION

Name of School:	Degree Received:	Start Date (MM/YY) :
		Graduation Date:
City:	State:	Country:
Name of School:	Degree Received:	Start Date (MM/YY):
		Graduation Date:
City:	State:	Country:

## 3. PROFESSIONAL TRAINING

Internship/Residency/Fellowship/Post Graduate Professional Training/Other

Have you had Cultural Competency Training?  Yes  No Date Completed:

Check here if entire section below is not applicable to Provider. List all, completed or not.

Training Institution:	Program: <input type="checkbox"/> Internship <input type="checkbox"/> Residency <input type="checkbox"/> Fellowship <input type="checkbox"/> Post Grad Training <input type="checkbox"/> Other:	
City:	State:	Country:
Program Completed: <input type="checkbox"/> Yes <input type="checkbox"/> No	Start Date (MM/YY):	Completion Date (MM/YY):
Training Institution:	Program: <input type="checkbox"/> Internship <input type="checkbox"/> Residency <input type="checkbox"/> Fellowship <input type="checkbox"/> Post Grad Training <input type="checkbox"/> Other:	
City:	State:	Country:
Program Completed: <input type="checkbox"/> Yes <input type="checkbox"/> No	Start Date (MM/YY):	Completion Date (MM/YY):
Training Institution:	Program: <input type="checkbox"/> Internship <input type="checkbox"/> Residency <input type="checkbox"/> Fellowship <input type="checkbox"/> Post Grad Training <input type="checkbox"/> Other:	
City:	State:	Country:
Program Completed: <input type="checkbox"/> Yes <input type="checkbox"/> No	Start Date (MM/YY):	Completion Date (MM/YY):

Provider Initials \_\_\_\_\_ Date \_\_\_\_\_ (Revised 11/18)

**4. STATE LICENSE(S): List all current and past professional licenses**

State	License #	Issue Date (MM/YY)	Expiration Date (MM/YY)	Status (Please check)
South Carolina				<input type="checkbox"/> Active <input type="checkbox"/> Inactive
				<input type="checkbox"/> Active <input type="checkbox"/> Inactive
				<input type="checkbox"/> Active <input type="checkbox"/> Inactive
				<input type="checkbox"/> Active <input type="checkbox"/> Inactive
				<input type="checkbox"/> Active <input type="checkbox"/> Inactive
				<input type="checkbox"/> Active <input type="checkbox"/> Inactive

**5. SPECIALTY BOARD CERTIFICATION**

Check here if entire section is not applicable

Are you board certified?  Yes  No (If yes, list below)

Certifying Board Name	Specialty	Initial Certification Date	Most Recent Recertification Date	Next Expiration Date

If not certified, are you qualified to sit for the examination?  Yes  No Date: \_\_\_\_\_

**6. HOSPITAL PRIVILEGES**

Do you have privileges at any hospital facility?  Yes  No

If no please describe arrangements for hospital care:

Hospital:		Department:		
Street:		City:	State:	Zip code:
Status of Privileges:	Affiliation date (MM/YY) From:		To:	% Admissions:
Hospital:		Department:		
Street:		City:	State:	Zip code:
Status of Privileges:	Affiliation date (MM/YY) From:		To:	% Admissions:
Hospital:		Department:		
Street:		City:	State:	Zip code:
Status of Privileges:	Affiliation date (MM/YY) From:		To:	% Admissions:
Hospital:		Department:		
Street:		City:	State:	Zip code:
Status of Privileges:	Affiliation date (MM/YY) From:		To:	% Admissions:

## 7. WORK HISTORY (CV cannot be used in lieu of completing this section)

List your employer and dates of employment for the past five years.

**Required:** Provide an explanation for gaps in work history:

Name of Previous/ Current Employer	Date of Employment (MM/YY)	
	<b>If still employed indicate "Present" in the first To: box</b>	
Current:	From:	To:
	From:	To:
	From:	To:
	From:	To:
	From:	To:

## 8. OFFICE PRACTICE INFORMATION PRIMARY SITE

Office practice name:

Office e-mail:

Practice Website:

Physical Office Location (address) Should the Provider display in the Directory at this location?  Yes  No

Street:

City:

State:

Zip code:

Appointment Phone:

Fax Number:

County:

Office Contact Person:

Phone #:

Email:

Credentialing Contact:

Phone #:

Email:

Group EIN/TIN#:

Group NPI#:

Group Medicare #:

Has your group signed agreement to participate with Medicare in the past twelve months?  Yes  No

### Office Hours

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
AM	AM	AM	AM	AM	AM	AM
PM	PM	PM	PM	PM	PM	PM

After hours phone number:

Handicap access:  Yes  No

Is your office equipped with telecommunication devices for the deaf?  Yes  No

Does your office offer 24/7 coverage?  Yes  No  
Please describe:

Is sign language assistance available?  Yes  No

Languages Spoken by staff:

List all Providers (including mid-levels) who are at this location. Indicate (P) for participating and (A) for applying by each name: If need more room, attach a separate sheet

Status	Provider

Billing Address  Same as Office Location

Name claims payable to:

Street/PO:

City:

State:

Zip code:

Phone #:

Fax #:

Mailing Address  Same as Office Location

Street/PO:

City:

State:

Zip code:

Phone #:

Fax #:

### PROVIDER PATIENT POPULATION

Does this provider see patients at this location?  Yes  No

If yes, do they accept new patients at this location?  Yes  No

Individual Medicaid #:

Do you accept Medicaid patients?  Yes  No

Are there patient age limitations?  Yes  No

Minimum Age:

Maximum Age:

Are there patient gender restrictions?  Yes  No

Males Only:

Females Only:

Please describe any other patient limitations:

**9. Additional Office Site-  Check here if not applicable**

For each additional location duplicate this page

Office practice name:

Office e-mail:

Practice Website:

Physical Office Location (address) **Should the Provider display in the Directory at this location?**  Yes  No

Street:

City:

State:

Zip code:

Appointment Phone:

Fax Number:

County:

Office Contact Person:

Phone #:

Email:

Credentialing Contact:

Phone #:

Email:

Group EIN/TIN#

Group NPI#

**Office Hours**

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
AM	AM	AM	AM	AM	AM	AM
PM	PM	PM	PM	PM	PM	PM

After hours phone number:

Handicap access:  Yes  No

Is your office equipped with telecommunication devices for the deaf?  Yes  No

Does your office offer 24/7 coverage?  Yes  No  
Please describe:

Is sign language assistance available?  Yes  No

Languages Spoken by staff:

List all Providers (including mid-levels) who are at this location. Indicate (P) for participating and (A) for applying by each name: If need more room, attach a separate sheet

Status	Provider

Billing Address  Same as Office Location

Name claims payable to:

Street/PO:

City:

State:

Zip code:

Phone #:

Fax #:

Mailing Address  Same as Office Location

Street/PO:

City:

State:

Zip code:

Phone #:

Fax #:

**PROVIDER PATIENT POPULATION**

Does this provider see patients at this location?  Yes  No

If yes, do they accept new patients at this location?  Yes  No

Do you accept Medicaid patients at this location?  Yes  No

Are there patient age limitations?  Yes  No

Minimum Age:

Maximum Age:

Are there patient gender restrictions?  Yes  No

Males Only:

Females Only:

Please describe any other patient limitations:

**10. Provider Disclosure Information (This section must be completed by Provider)**

If you answer **yes** to any of the questions listed below, **please include** a detailed explanation of each answer on the following page. The explanation must accompany the application for it to be considered a complete application.

PROVIDER NAME:

1. Do you have any pending misdemeanor or felony charges?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2. Have you ever been convicted of a felony?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3. Has your license to practice medicine in any jurisdiction ever been voluntarily or involuntarily denied, restricted, suspended, challenged, revoked, conditioned or otherwise limited?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
4. In the past five years and up to and including the present, have you had any ongoing physical or mental impairment or condition which would make you unable, with or without reasonable accommodation, to perform the essential functions of a practitioner in your area of practice, or unable to perform those essential functions without a direct threat to the health and safety of others?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
5. Considering the essential functions of a practitioner in your area of practice is the past five years and up to and including the present, have you suffered from any communicable health condition that could pose a significant health and safety risk to your patients?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
6. Have you ever been publicly reprimanded or disciplined by a professional licensing agency or board?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
7. Has your DEA certification or state controlled drug permit ever been restricted, suspended, revoked, voluntarily relinquished or otherwise limited?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
8. Have any of your privileges or memberships at any hospital or institution ever been denied, suspended, reduced, revoked, not renewed or otherwise limited?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
9. Has your participation in Medicare, Medicaid, or any other government program ever been limited, curtailed or have you voluntarily excluded yourself from any of these programs?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
10. Has your participation in an Insurance Company network ever been limited or terminated?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
11. In the past five year and up to the present, have you had a history of chemical dependency or substance abuse that might affect your ability to competently and safely perform the essential functions of a practitioner in your area of practice?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
12. In the past five years and up to and including the present, have you had or do you have any mental or physical condition or do you take any medications that might affect your ability to competently and safely perform the essential functions of a practitioner in your area of practice?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
13. Has any malpractice carrier ever made an out-of-court settlement or paid a judgement of a medical malpractice claim on your behalf or are any medical malpractice suits pending against you?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
14. Has your professional liability insurer ever placed conditions or restrictions on your coverage or ability to obtain coverage?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
*IF YES TO ANY OF THE ABOVE EXPLAIN ON THE FOLLOWING PAGE		

**(The above information will be held strictly confidential.)**



Check here if this page was left blank intentionally

PLEASE USE THIS PAGE FOR ANY QUESTIONS THAT YOU ANSWERED YES TO ON THE ABOVE PAGE  
Prewritten explanations may be attached in lieu of a written explanation below

# 11. AUTHORIZATION

I CERTIFY THAT ALL INFORMATION CONTAINED IN THIS APPLICATION AND ALL ITS ATTACHMENTS ARE ACCURATE, COMPLETE AND TRUE.

I understand that:

- A. Any misrepresentation, misstatement or omission of a relevant fact in connection with this application may result in denial of my application or termination of my participation in the Managed Care Organization;
- B. It is my responsibility to promptly advise the Managed Care Organization in writing within 30 days of any changes or additions to the information contained in this application;
- C. All the information contained in this application, or its attachments, is subject to the Managed Care Organization’s investigation and review and;
- D. This is an application only and my submission of this application does not automatically result in participation with the Managed Care Organization;

**NOTICE:** The National Practitioner Data Bank will be queried if you apply. If your application is rejected for reasons relating to professional conduct or professional competence, which reasons include misrepresenting, misstating, or omitting a relevant fact in connection with your application, the rejection may be reported to The National Practitioner Data Bank.

I authorize the Managed Care Organization to consult with administrators and members of the medical staffs of hospitals or institutions with which I have been or am currently associated, and with others, including without limit past and present malpractice carriers, who may have information bearing on my professional competence, character and ethical qualifications. I further consent to the inspection by agents, employees, contractors, affiliates or other representatives of the Managed Care Organization of all documents that may be material to an evaluation of my professional competence, character and ethical qualifications.

I release from liability the Managed Care Organization and all representatives of the Managed Care Organization for their acts performed in good faith and without malice or negligence in connection with evaluating my application and my credentials and qualifications, and I release from any liability any and all individuals and organizations who provide information to the Managed Care Organization in good faith and without malice or negligence concerning my professional competence, character and ethics. I consent to the release and exchange of information as allowed by law relating to any application, investigation, disciplinary action, suspension, or curtailment of participation status, membership and/or privileges of any type to or from the Managed Care Organization.

NAME: \_\_\_\_\_  
(Applicant Name print or type)

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_  
(Applicant)

*EACH SUBMISSION REQUIRES AN ORIGINAL SIGNATURE AND CURRENT DATE.*

Providers have the right to:

- 1. Review information submitted to support the credentialing application**
- 2. Correct erroneous information**
- 3. Be informed of the status of the credentialing application**

**Providers will hear from us:**

- 1. Submission of application**
- 2. If application is incomplete or moving onto the onboarding status**
- 3. During any delays**
- 4. Once the provider is credentialed**

To exercise the above rights, please email your inquiries to [Provider.credentialing@bcssc.com](mailto:Provider.credentialing@bcssc.com)

**For Status Inquires please fill out [website form](#)**

**Submit completed applications to [Provider.Blue.Enroll@bcssc.com](mailto:Provider.Blue.Enroll@bcssc.com) or fax 803-870-8919**

## Electronic Claims Filing Requirement

*Your practice must file a minimum of 90% of claims in a HIPAA compliant electronic format to qualify for network participation.*

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My practice currently has the ability to meet this requirement: (Check one)  Yes  No

If yes, please indicate below how you plan to meet this requirement. (Check all that are applicable)

File direct via the web at [www.SouthCarolinaBlues.com](http://www.SouthCarolinaBlues.com) or [www.BlueChoiceSC.com](http://www.BlueChoiceSC.com) (Free)

File through an outside billing agency or vendor:  
(Please indicate the name of billing agency or vendor used)

Companion Technologies

Misys

McKesson HBOC

Medware/ Per'Se

Web MD/Envoy

MedUnite

Other \_\_\_\_\_  
(Please write in name)

Practice Name: \_\_\_\_\_

Practice Tax I.D.: \_\_\_\_\_

Practice Manager: \_\_\_\_\_

Phone #: \_\_\_\_\_

Physician or Practitioner Name: \_\_\_\_\_

*Please return this form with your Preferred Blue<sup>®</sup> and BlueChoice HealthPlan application*