Physician Recognition Program Payment Request Form

To apply for payment, please provide all of the requested information for each individual physician or practice (Patient-Centered Medical Home) and return this form along with a copy of your letter(s) of recognition and current W-9 form.

1. Physician or Practice Information:

   Name: _____

   Social Security #: _____

   Billing #: _____

   Group Practice Name:_____

   Address to Send Payment:

   _____
   Street

   _____
   City, State, ZIP Code

2. Please check the Plans you contract with: ___ BlueCross Preferred Blue® ___ BlueChoice HealthPlan

3. Please complete this information for the Physician Recognition programs you are requesting payment from. (Be sure to enclose your letter(s) of recognition or certification.)

Newly Certified Date	Recertified Date	Program
__/__/__	___/__/__	ADA/NCQA Diabetes Physician Recognition Program
__/__/___	__/__/___	AHA/ASA/NCQA Heart/Stroke Recognition Program
__/__/___	__/__/___	American Society of Hypertension (ASH) Specialists Program
__/__/___	N/A	NCQA Patient-Centered Medical Home Recognition Program (practice level only)

4. Please check one of the following and date this application to indicate you have met and agree to the BlueCross BlueShield of South Carolina/BlueChoice HealthPlan Physician Recognition Payment Terms and Conditions.

   ____ I certify that neither I nor my practice has previously received payment or applied for payment under this new program year.

   ____ I certify that I or my practice has received payment for one program this year.

   _____ _____
   Signature Date

5. Complete the W-9 form.

6. Send the W-9, Request Form and Letter/Certificate of Achievement to:

   BlueCross BlueShield of South Carolina
   Attn: Ashley Hitchcock, AX-305
   PO Box 6170
   Columbia, SC 29260-6170