South Carolina

BlueChoice® HealthPlan
South Carolina

To Apply for BlueCross BlueShield of South Carolina and BlueChoice HealthPlan

1. Complete the SC Uniform Managed Care Provider Credentialing Application.

2. Enclose copies of the following items:

A. State licenses(s)
B. Current DEA certificate
C. Proof of malpractice coverage, including supplemental coverage
D. Board specialist certificate, if applicable
E. Electronic Claims Filing Requirement Form
F. NPI NPPES confirmation letter or email
G. If this is a new office location, appropriate IRS documentation (*Letter 147C, CP 575 E or tax coupon 8109-C)* and NPI NPPES confirmation letter or email to new location
H. A **signed** contract signature page for each network to which you wish to apply.
***If you need copies of contract signature pages for Preferred Blue®, State Health Plan, Preferred Dental, Medicare Advantage, BlueChoice HealthPlan networks and BlueChoice HealthPlan Medicaid (MCO) network, please email your requests to: cred.fax@bcbssc.com.**

3. Complete the following for our provider information database:

A. The **date** this provider will **start working** for your group: _____
B. Your website URL: _____

The managed care plans in South Carolina combined their efforts to create the SC Uniform Managed Care Provider Credentialing Application. We accept this application for the following BlueCross BlueShield of South Carolina and BlueChoice HealthPlan plans:

1. Preferred Blue
2. State Health Plan
3. Preferred Dental Network
4. Medicare Advantage
5. BlueChoice HealthPlan Networks
6. BlueChoice HealthPlan Medicaid (MCO) Network

In order to meet consumer demand for additional provider information, we are cooperating with the Blue Cross and Blue Shield Association to collect the following for display on its national website. This information is included as part of the attached application:

1. Foreign language(s) spoken by the practitioner or by a member of your office staff
2. Office hours
3. If accepting new patients
4. Office website address
5. Practitioner gender
6. Month/year graduated from medical school
7. Board certification
8. Primary admitting privileges

Fax completed application, documentation and contract signature page(s) to 803-264-4795.

Enter text directly into this form by placing your cursor on each blank. Click on boxes to select them, or tab to them and press your spacebar. You can also save this form to your computer. Use the "Clear Form" button on the right to delete all answers. Print the form and fax it to us to complete your application.

SC Uniform Managed Care Provider Credentialing Application

I. PERSONAL INFORMATION

☐ Solo Practice or ☐ Group Practice

Name: Last _____ First _____ M.I. _____ Suffix _____ Degree _____

Maiden and/or other name: _____

(List W-9 Name if different _____)

Place of Birth: (City) _____, (State) _____ Date of Birth: _____

If you are not a U.S. Citizen, do you have authorization to work in the U.S.? ☐ Yes ☐ No

☐ Male ☐ Female (*OPTIONAL). This information will not be used by the Managed Care Organization in making its determination regarding your participation*.

Social Security Number: _____ NPI: _____ UPIN Number: _____

Practice Name: _____

Tax ID Number: _____ Group NPI: _____

E-mail address of practitioner: _____

II. MEDICAL LICENSE/REGISTRATION

A. If you are a family practitioner, do you offer OB care? ☐ Yes ☐ No

B. Do you speak any foreign language fluently that you would like added to the directory? ☐ Yes ☐ No

If yes, please specify: _____

C. ECFMG Number: _____

Current Professional License Number(s) (indicate if not applicable): NA ☐

1. SC Medical License Number: _____ Issue Date: _____ Expiration Date: _____

2. Additional Medical State Licenses and Numbers:

State: _____ License Number: _____ Issue Date: _____ Expiration Date: _____

State: _____ License Number: _____ Issue Date: _____ Expiration Date: _____

State: _____ License Number: _____ Issue Date: _____ Expiration Date: _____

3. DEA No.: _____ Expiration Date: _____ SC Cont. Drug Perm. No.: _____ Expiration. Date: _____

History of Previous Licensure in all Jurisdictions (indicate if not applicable): NA ☐

State: _____ License Number: _____ Issue Date: _____ Expiration Date: _____

State: _____ License Number: _____ Issue Date: _____ Expiration Date: _____

State: _____ License Number: _____ Issue Date: _____ Expiration Date: _____

III. EDUCATION/TRAINING/HOSPITAL PRIVILEGES

1. Medical School Institution: _____

City: _____ State: _____ Country: _____

Date of Entry: _____ Graduation Date (MMYY): _____ Degree: _____

Internship Institution: _____ Specialty: _____

City: _____ State: _____ Country: _____

Program Completed: ☐ Yes ☐ No Date of Entry (MMYY): _____ Completion Date (MMYY): _____

Residency Institution: _____ Specialty: _____

City: _____ State: _____ Country: _____

Program Completed: ☐ Yes ☐ No Date of Entry (MMYY): _____ Completion Date (MMYY): _____

Fellowship Institution: _____ Specialty: _____

City: _____ State: _____ Country: _____

Program Completed: ☐ Yes ☐ No Date of Entry (MMYY): _____ Completion Date (MMYY): _____

2. CME REQUIREMENTS:

Number of CME credits completed in the last two years: _____

3. HOSPITAL STAFF PRIVILEGES

Name: _____

Address: _____

Department: _____ Dates of Affiliation: From (MMYY): _____ To (MMYY): _____

Status of Privileges: _____ % of Admissions: _____

Additional Hospital Name: _____

Address: _____

Department: _____ Dates of Affiliation: From (MMYY): _____ To (MMYY): _____

Status of Privileges: _____ % of Admissions: _____

Additional Hospital Name: _____

Address: _____

Department: _____ Dates of Affiliation: From (MMYY): _____ To (MMYY): _____

Status of Privileges: _____ % of Admissions: _____

If you do not admit please describe arrangements to provide hospital care: _____

_____

Provider Initials: _____ **Date:** _____

IV. MEDICAL SPECIALTIES

MEDICAL SPECIALTIES	CERTIFYING BOARD	DATE CERTIFIED	EXPIRATION DATE
Primary			
If not Board certified, do you plan to take certifying exam? ☐ Yes, Date		☐ No	
Secondary			
If not Board certified, do you plan to take certifying exam? ☐ Yes, Date		☐ No	

Under which specialty do you wish to be listed in the Directory? _____

Are you applying for participation as:

Primary Care Physician: ☐ Specialist: ☐ Non-Physician Practitioner: ☐

V. MALPRACTICE INFORMATION

You are required to maintain malpractice insurance of an adequate and acceptable amount reflective of your specialty as a prerequisite for participating in a managed care organization. Please *attach* a copy of your most recent malpractice insurance binder.

List current and previous malpractice insurance carrier(s) for past five years:

CARRIER NAME/ADDRESS	POLICY NUMBER	EFFECTIVE DATE	EXPIRATION DATE	AMOUNT OF COVERAGE

VI. Five Year Work History *(CV can not be used in lieu of completing this section)*

NAME OF PREVIOUS/CURRENT EMPLOYER(S)	DATE OF EMPLOYMENT (MM/DD/YY-MM/DD/YY)
1.	
2.	
3.	
4.	
5.	

Please provide an explanation of any gaps in employment: _____

_____

Signature: _____ Date: _____

RUBBER STAMPED AND ELECTRONIC SIGNATURES ARE NOT ACCEPTABLE

Please print name: _____

VII. PLEASE ANSWER THE FOLLOWING QUESTIONS
(This section must be completed by practitioner)

Managed Care Organizations must have complete liability information and written explanations to begin the credentialing process. *(If you answer "Yes" to any of the questions listed below, please enclose a detailed explanation.)*

1. Do you have any pending misdemeanor or felony charges? ☐ Yes ☐ No
2. Have you ever been convicted of a felony? ☐ Yes ☐ 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? ☐ Yes ☐ 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? ☐ Yes ☐ No
5. Considering the essential functions of a practitioner in your area of practice, in 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? ☐ Yes ☐ No
6. Have you ever been publicly reprimanded or disciplined by a professional licensing agency or board? ☐ Yes ☐ No
7. Has your DEA certification or state controlled drug permit ever been restricted, suspended, revoked, voluntarily relinquished or otherwise limited? ☐ Yes ☐ 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? ☐ Yes ☐ 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? ☐ Yes ☐ No
10. Has your participation in an Insurance Company network ever been limited or terminated? ☐ Yes ☐ No
11. In the past five years 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? ☐ Yes ☐ 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: ☐ Yes ☐ No
13. Has any malpractice carrier ever made an out-of-court settlement or paid a judgment of a medical malpractice claim on your behalf or are any medical malpractice suits pending against you? ☐ Yes ☐ No
14. Has your professional liability insurer ever placed conditions or restrictions on your coverage or ability to obtain coverage? ☐ Yes ☐ No

(THE ABOVE INFORMATION WILL BE HELD STRICTLY CONFIDENTIAL.)

VIII. 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: _____
(print or type)

SIGNATURE: _____ **DATE:** _____
(Applicant)

Must be signed in ink
EACH SUBMISSION REQUIRES AN ORIGINAL SIGNATURE AND CURRENT DATE.
Rubber Stamped and Electronic Signatures Are Not Acceptable

Practitioners have the right to review information obtained to evaluate their credentialing and recredentialing applications.

SC Uniform Managed Care Office Information

I. GENERAL INFORMATION

A. Do you accept Medicaid patients? ☐ Yes Medicaid ID number: _____ No ☐

B. Have you signed an agreement to participate with Medicare in the past twelve months? ☐ Yes Medicare Group ID number: _____ No ☐

C. Are you accepting new patients? ☐ Yes No ☐

D. Are there any age limitations? ☐ Yes, Minimum Age: _____ Maximum Age: _____ No ☐

E. Are there gender restrictions? Males Only ☐ Females Only ☐ Both/ no restrictions ☐

Please describe any other patient limitations:

_____

II. OFFICE INFORMATION

A. Office Address: (physical) _____

1. Practice Name: _____ EIN# : _____
2. Street: _____ City: _____ County: _____ State: _____ (Zip) _____
3. Appointment Phone: _____ Fax: _____
4. Office Contact Person: _____
5. Credentialing Contact Phone Number: _____
6. List of all practitioners (including physician extenders) 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	Practitioner

7. Do you offer 24-hour/7-day coverage? ☐ Yes ☐ No Please describe: _____

_____

8. List physicians who are not a part of your practice with whom you share call: _____

_____

9. What hours are you available to see patients in this office:

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
From/To							

10. After hours phone number: _____
11. Is your office equipped with telecommunications devices for the deaf (TDD): ☐ Yes ☐ No
12. Sign language assistance available: ☐ Yes ☐ No
13. Languages spoken by office staff: _____
14. Handicap Access: ☐ Yes ☐ No

B. Billing Address: (if different)

1. Name claims payable to: _____
2. Street/PO: _____ City: _____ State: _____ Zip: _____
3. Phone: _____ Fax: _____

C. Mailing Address: (if different)

1. Street/PO: _____ City: _____ State: _____ Zip: _____
2. Phone: _____ Fax: _____

D. Office e-mail address (if any): _____

E. Practice Web site address (if any): _____

ATTACHMENT -FOR EACH ADDITIONAL SATELLITE OFFICE LOCATION, DUPLICATE THIS PAGE

A. Satellite Office Address (physical):

1. Practice Name: _____ EIN#: _____
2. Street: _____ City: _____ County: _____ State: _____ Zip: _____
3. Phone: _____ Fax: _____
4. Office Contact Person: _____
5. Credentialing Contact Phone Number: _____
6. List of practitioners (including physician extenders) who are billing at this location. Indicate (P) for Participating and (A) for applying by each name. If need more room, attach a separate sheet.

Status	Practitioner

7. Do you offer 24-hour/7-day coverage? ☐ Yes ☐ No Please describe: _____
8. List physicians who are not a part of your practice with whom you share call: _____
9. What hours are you available to see patients in this office:

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
From/To							

10. After hours phone number: _____
11. Is your office equipped with telecommunications devices for the deaf (TDD): ☐ Yes ☐ No
12. Sign language assistance available: ☐ Yes ☐ No
13. Languages spoken by office staff: _____
14. Handicap Access: ☐ Yes ☐ No

B. Billing Address: (if different)

1. Street/PO: _____ City: _____ State: _____ Zip: _____
2. Phone: _____ Fax: _____

C. Mailing Address: (if different)

1. Street/PO: _____ City: _____ State: _____ Zip: _____
2. Phone: _____ Fax: _____

D. Office e-mail address: _____

E. Practice Web site address (if any): _____

South Carolina

BlueChoice® HealthPlan
South Carolina

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.

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 or 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® and BlueChoice HealthPlan application

South Carolina

BlueChoice® HealthPlan South Carolina

Authorization for Clinic/Group to Bill for Services

Please complete this form to notify BlueCross BlueShield of South Carolina and BlueChoice HealthPlan that you have authorized a clinic/group/institution/location to bill for your services for Preferred Blue® (PPC), FEP and/or the State Health Plan and BlueChoice HealthPlan. Fax the completed form to 803-264-4795. If you have questions, email Provider.Cert@bcbssc.com.

This form does not qualify you to be a network provider.

BlueCross BlueShield of South Carolina and BlueChoice HealthPlan reserve the right to accept or refuse authorization for a clinic/group/professional association/institution to bill for services.

(Please type or print)

Date of Request_____

I agree that _____ will bill for and receive charges or fees for my services
(Name of Clinic, Group or Professional Association)

effective _____.
(Date: MMDDYYYY)

_____
(Signature of Practitioner)

_____
(Practitioner's Name Printed)

_____
(Practitioner's Social Security Number)

_____
(Practitioner's National Provider Identifier)

_____
(Practitioner's License Number)

Clinic/Group/Professional Association/Institution Physical Address:

_____

_____

Payment Address:

_____

_____

_____
(Signature of Clinic/Group/Professional Association/Institution Representative)

_____
(Title of Clinic/Group/Professional Association/Institution Representative)

_____
(Representative's Contact Telephone Number)

Email Address (required for notification when we complete changes)

_____

Enter text directly into this form by placing your cursor on each blank. Click on boxes to select them, or tab to them and press your spacebar. You can also save this form to your computer. Use the "Clear Form" button on the right to delete all answers. Print the form and fax it to us to complete your application.