

# PROVIDER ENROLLMENT



South Carolina

*BlueCross BlueShield of South Carolina  
is an independent licensee of the  
Blue Cross Blue Shield Association.*

# AGENDA

- Provider Enrollment Requirements
- Enrollment Process Overview
- Provider Enrollment Reminders
- My Provider Enrollment Portal Overview
- Completing a Clean Application
- Making Corrections to Applications
- Resources



# **PROVIDER ENROLLMENT REQUIREMENTS**



# PROVIDER ENROLLMENT REQUIREMENTS

## Provider Enrollment Applications and Forms

Application or form	Used for...
Individual Enrollment	New practitioners that want to enroll with BlueCross ( <b>not for Behavioral Health</b> )
Group Practice Enrollment	New groups that want to enroll with BlueCross
Facility Information Request	New medical facilities that want to credential with BlueCross
Virtual Care Services	Practitioners or groups that want to render telemedicine and telehealth services
Health Professional	<u>In-state, out-of-network</u> practitioners that want to file claims to BlueCross
Behavioral Health	New practitioners or groups that want to enroll in our behavioral health network
Autism Provider Panel	Applied behavior analysts that want to enroll in our autism provider panel
Doing Business As Name Change	Changing the doing business as (DBA) name of a practice
Change of Address	Updating the physical, pay to, correspondence or billing agency address
Satellite Location	<u>Enrolled groups</u> that have <u>new locations</u> that want to file claims
NPI Provider Notification	<u>Out-of-state and out-of-network</u> practitioners that need to register their NPI with BlueCross
Add or Terminate Practitioner	Adding or terminating a practitioner's affiliation with a clinic, group or institution

# PROVIDER ENROLLMENT REQUIREMENTS

## What to Include: Individual Enrollment – Ancillary Providers (Speech, Physical, Occupational and Audiology)

Checklist Items
Provider Enrollment Application
Copy of SC Medical or Practice License
Current Copy of Malpractice (Min. \$1M/\$3M)
Authorization to Bill for Services
Signed Contracts
Hold Harmless*
Appendix D*
Medicaid ID Number**

\*Only if applying for BlueChoice HealthPlan.

\*\*Only if applying for Healthy Blue.

# PROVIDER ENROLLMENT REQUIREMENTS

## What to Include: Individual Enrollment – Dental Providers

Checklist Items	Oral Surgery	Routine
Provider Enrollment Application		
Copy of SC Medical or Practice License		
Drug Enforcement Administration (DEA) Certification*		
Current Copy of Malpractice (Min. \$1M/\$3M)		
Authorization to Bill for Services		
Signed Contracts	Footnote 1	Footnote 2
Professional Training		
Hold Harmless**		
Appendix D**		
Medicaid ID Number***		

\*Only if applicable.

\*\*Only if applying for BlueChoice HealthPlan.

\*\*\*Only if applying for Healthy Blue.

1 Medical contract, dental contract or both.

2 Dental contract only.

# PROVIDER ENROLLMENT REQUIREMENTS

## What to Include: Individual Enrollment – Mid-Level Providers

Checklist Items	NP	PA	CRNA/AA	Midwife	CNS	Hospitalist
Provider Enrollment Application						
Copy of SC Medical or Practice License						
Drug Enforcement Administration (DEA) Certification*						
Current Copy of Malpractice (Min. \$1M/\$3M)						
Authorization to Bill for Services						
Nurse Practitioner Preceptor Form						
Protocols (Written Agreement)						
Signed Contracts						
Hold Harmless**						
Appendix D**						
Medicaid ID Number***						
Professional Training****						

**NP: Nurse Practitioner**

**PA: Physician Assistant**

**CRNA: Certified Registered Nurse Anesthetist**

**CNS: Clinical Nurse Specialist**

\*Only if applicable.

\*\*Only if applying for BlueChoice HealthPlan.

\*\*\*Only if applying for Healthy Blue.

\*\*\*\*Required for MDs, DOs and DPMs.

# PROVIDER ENROLLMENT REQUIREMENTS

## What to Include: Individual Enrollment – Pharmacists

Checklist Items
Provider Enrollment Application
Copy of SC Medical or Practice License
Drug Enforcement Administration (DEA) Certification*
Current Copy of Malpractice (Min. \$1M/\$1M)
Authorization to Bill for Services
Signed Contracts
Hold Harmless**
Appendix D**
Medicaid ID Number***

\*Only if applicable.

\*\*Only if applying for BlueChoice HealthPlan.

\*\*\*Only if applying for Healthy Blue.



# PROVIDER ENROLLMENT REQUIREMENTS

## What to Include: Individual Enrollment – Physicians and Chiropractors

Checklist Items
Provider Enrollment Application
Copy of SC Medical or Practice License
Drug Enforcement Administration (DEA) Certification*
Current Copy of Malpractice (Min. \$1M/\$3M)
Authorization to Bill for Services
Signed Contracts
Professional Training**
Hold Harmless***
Appendix D***
Medicaid ID Number****

\*Only if applicable.

\*\*Required for MDs, DOs and DPMs.

\*\*\*Only if applying for BlueChoice HealthPlan.

\*\*\*\*Only if applying for Healthy Blue.

# PROVIDER ENROLLMENT REQUIREMENTS

## What to Include: Group Practice Enrollment – Ambulance

Checklist Items
Group Practice Application
IRS Verification of Tax ID (Letter 147C or CP 575 E)
Electronic Funds Transfer
Signed Contracts
Medicaid ID Number*
Copy of CMS Letter

\*Only if applying for Healthy Blue.

# PROVIDER ENROLLMENT REQUIREMENTS

## What to Include: Group Practice Enrollment – Dental

Checklist Items
Group Practice Application
IRS Verification of Tax ID (Letter 147C or CP 575 E)
Electronic Funds Transfer
Signed Contracts*
Medicaid ID Number**
Add Practitioner Form***

\*For oral surgeons applying for BlueChoice and Healthy Blue. All other contracts are based on the individual practitioner's credentialing status.

\*\*Only for oral surgeons applying for Healthy Blue.

\*\*\*For each physician being added to the group. This form does not generate with the group application. It is under the Find a Form section of the portal. Note: If the provider is not credentialed, you must complete the Provider Enrollment application.

# PROVIDER ENROLLMENT REQUIREMENTS

## What to Include: Group Practice Enrollment – Durable Medical Equipment

Checklist Items
Group Practice Application
IRS Verification of Tax ID (Letter 147C or CP 575 E)
Electronic Funds Transfer
Signed Contracts
Medicaid ID Number*
Copy of CMS Letter with Medicare PTAN
Copy of Business License

\*Only if applying for Healthy Blue.

# PROVIDER ENROLLMENT REQUIREMENTS

**What to Include: Group Practice Enrollment – Home Health, Hospice, Dialysis, Hospitals, Skilled Nursing and ASC**

Checklist Items
Group Practice Application
IRS Verification of Tax ID (Letter 147C or CP 575 E)
Electronic Funds Transfer
Signed Contracts
Medicaid ID Number*
Copy of CMS Letter
Copy of Business License
Copy of DHEC License

**\*Only if applying for Healthy Blue.**

# PROVIDER ENROLLMENT REQUIREMENTS

## What to Include: Group Practice Enrollment – Pharmacy

Checklist Items
Group Practice Application
IRS Verification of Tax ID (Letter 147C or CP 575 E)
Electronic Funds Transfer
Signed Contracts
Medicaid ID Number*
Copy of CMS Letter with Medicare PTAN
Copy of DHEC License

\*Only if applying for Healthy Blue.

# PROVIDER ENROLLMENT REQUIREMENTS

## What to Include: Group Practice Enrollment – Physician Office

Checklist Items
Group Practice Application
IRS Verification of Tax ID (Letter 147C or CP 575 E)
Electronic Funds Transfer
Signed Contracts**
Medicaid ID Number*
Add Practitioner Form***

\*Only if applying for Healthy Blue.

\*\*Only for BlueChoice and Healthy Blue. All other commercial contracts are based on the individual practitioner's credentialing status.

\*\*\*For each physician being added to the group. This form does not generate with the group application. It is under the Find a Form section of the portal. Note: If the provider is not credentialed, you must complete the Provider Enrollment application.

# PROVIDER ENROLLMENT REQUIREMENTS

## What to Include: Behavioral Health

Checklist Items
Behavioral Health or Autism Panel Application
IRS Verification of Tax ID (or W9)
Professional Agreements (includes Hold Harmless and Appendix C)
Copy of SC State License
Copy of DEA License (if applicable)
Copy of Board Certification (if applicable)
Nurse Protocols (NPs only)
Current Copy of Malpractice (Min. \$1M/\$3M)



# PROVIDER ENROLLMENT REQUIREMENTS

## What to Include: In State, Out-of-Network

### *Individual Physician*

Checklist Items
Health Professional Application*
Authorization to Bill for Services*

\*Needed for each individual being linked to the practice.

### *Group Practice*

Checklist Items
Group Practice Application
IRS Verification of Tax ID (Letter 147C or CP 575 E)
Electronic Funds Transfer Enrollment

**Note:** Groups that wish to remain out-of-network must select “No” for the network participation question on the application.

# PROVIDER ENROLLMENT REQUIREMENTS

## What to Include: Out-of-State, Out-of-Network

Checklist Items
NPI Notification Form
Copy of W9

# PROVIDER ENROLLMENT REQUIREMENTS

## What to Include: Satellite Locations

Checklist Items
Satellite Location Application
IRS Verification of Tax ID (Letter 147C or CP 575 E)
Electronic Funds Transfer*
Add Practitioner Form**
Authorization to Bill for Services***
Hold Harmless***
Appendix D***

\*Only if a new NPI is being registered.

\*\*For each physician being added to the group. This form does not generate with the group application. It is under the Find a Form section of the portal. Note: If the provider is not credentialed, you must complete the Provider Enrollment application.

\*\*\*Only if the practitioner is not associated with other locations.

# PROVIDER ENROLLMENT REQUIREMENTS

## Signature Requirements

Medical Networks	
Application or Form	Signature Requirements
Provider Enrollment	Electronic or wet
Recredentialing	Electronic or wet
Facility Information Request	Electronic or wet
Health Professional	Electronic or wet
Doing Business As	Electronic or wet
Change of Address	Electronic or wet
Add/Term Practitioner	Electronic or wet
Authorization to Bill	Electronic or wet
Electronic Funds Transfer (EFT)	Wet
Appendix D (BlueChoice® HealthPlan)	Wet
Hold Harmless (BlueChoice®)	Wet
ALL Contracts	Wet

Behavioral Health Network	
Application or Form	Signature Requirements
Behavioral Health	Electronic or wet
Autism Panel	Electronic or wet
Facility Information Request	Electronic or wet
Authorization to Bill	Electronic or wet
ALL Contracts	Electronic or wet



# **OVERVIEW OF THE ENROLLMENT PROCESS**



# OVERVIEW OF THE ENROLLMENT PROCESS

## Clean Application Process

1. Enrollment team receives complete enrollment application
2. Application is reviewed for completion and sent to the Credentialing Committee
  - Only complete and accurate applications are sent to the committee.
    - For applications with missing/incomplete documentation, providers are notified **21 days** to submit the requested items.
    - If the missing items are not received within **28 days**, the application is canceled.
  - Non-approved applications go to the Disciplinary Committee for approval or denial
    - The verdict is sent to the provider.
3. Approved applications are sent to Contracting for review
  - Approved contracts are executed
4. Welcome email and packet (with effective dates) is sent to the provider

# OVERVIEW OF THE ENROLLMENT PROCESS

## Clean Application Process – Things to Keep in Mind

- The Credentialing Committee reviews all enrollment applications to ensure all required credentialing criteria are met:
  - Utilization Review Accreditation Commission (URAC)
  - National Committee for Quality Assurance (NCQA)
  - South Carolina Department of Health & Human Services (SCDHHS), when applicable
- Effective dates are based on the Credentialing Committee's approval date, per URAC requirements
- Backdating **network dates** is not allowed
  - Affiliation dates can be backdated.
    - Up to Jan. 1<sup>st</sup> of the previous year (e.g., affiliations for 2024 can go back up to Jan. 1, 2023)
      - If the application is pending, email documentation requesting the backdated affiliation date to [Provider.Requested.Info@bcbssc.com](mailto:Provider.Requested.Info@bcbssc.com).
      - If the application is completed, fax the documentation to 803-264-4795.



# **PROVIDER ENROLLMENT REMINDERS**





# PROVIDER ENROLLMENT REMINDERS

## Missing items – Common Missing Items That Cause Delays in the Processing of Applications

### Unsigned applications and contracts

#### ***For applications***

1. Select My Forms
2. Select the appropriate case number
3. Select Form Information
4. Under Documents, select the document(s) that require signature
5. Download the document(s) and have the signature(s) appended
6. Scan the documents and follow steps 1 – 4 and select Upload Files
7. Select the Confirm button to attest that **all required documentation with applicable signatures, initials and dates** have been uploaded

#### ***For contracts***

1. Select My Contracts
2. Select the appropriate form contract name that corresponds with your case number
3. Under Download Contract, select the link to download and sign the contract
4. Scan the documents and follow steps 1 – 2 and select Upload Files

### Invalid dates

- Malpractice dates must be valid and active on or before the requested starts date.
- Signature dates on contracts and applications must be current.

#### ***IMPORTANT NOTE:***

*An automated notification for missing items is sent every seven days until the information is received. Outreach is made on:*

- ***Day 7 – First request***
- ***Day 14 – Second request***
- ***Day 21 – Third (final) request***

*If the missing items are not received, the case will be placed in the “Canceled – Incomplete Submission” status. Once in this status, it cannot be reopened, and a new application must be completed.*

# PROVIDER ENROLLMENT REMINDERS

## Missing items – Common Missing Items That Cause Delays in the Processing of Applications (Continued)

### Incomplete submissions

- Missing a copy of the following:
  - State/medical license
  - DEA license
  - CLIA certificate
  - Malpractice verification

**\*Upload a copy of your Active State License.**

State License Upload\*

Add File...

**Federal DEA**

Do you currently hold a federal DEA registration in each State you prescribe controlled substances?\*

Yes

*If DEA app has been submitted and is PENDING, DDS will not write prescriptions until DEA is finalized.*

DEA License File\*

Add File...

\*. required

Back Save & Exit Next

Note - If you are CLIA certified, please submit copy of the certificate\*

Add File...

\*Upload a copy of your malpractice insurance verification. This must include the practitioner's name on the certificate to be valid.

Upload Malpractice Insurance\*

Add File...

### **IMPORTANT NOTE:**

*An automated notification for missing items is sent every seven days until the information is received. Outreach is made on:*

- **Day 7 – First request**
- **Day 14 – Second request**
- **Day 21 – Third (final) request**


*If the missing items are not received, the case will be placed in the “Canceled – Incomplete Submission” status. Once in this status, it cannot be reopened, and a new application must be completed.*

# PROVIDER ENROLLMENT REMINDERS

## Missing items – Common Missing Items That Cause Delays in the Processing of Applications (Continued)

### Incomplete documentation

- Authorization to Bill missing effective dates and representative details

 BlueCross BlueShield of South Carolina and BlueChoice HealthPlan of 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 and FEP)
- State Health Plan
- Medicare Advantage
- Blue Essentials
- Blue Option<sup>SM</sup>
- Healthy Blue<sup>SM</sup>
- BlueChoice HealthPlan

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

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

Date of Request: \_\_\_\_\_

I agree that \_\_\_\_\_ will bill for and receive charges or fees for my services effective \_\_\_\_\_

EIN Number: \_\_\_\_\_

\_\_\_\_\_  
Signature of Practitioner

\_\_\_\_\_  
Practitioner's Name Printed

\_\_\_\_\_  
Practitioner's SSN and NPI

\_\_\_\_\_  
Signature & Title of Clinic/Group/Professional Association/Institution Representative

\_\_\_\_\_  
Representative's Contact Telephone Number

\_\_\_\_\_  
Email Address (required for notification)

All highlighted fields  
**MUST** be completed.

### **IMPORTANT NOTE:**

*An automated notification for missing items is sent every seven days until the information is received. Outreach is made on:*

- **Day 7 – First request**
- **Day 14 – Second request**
- **Day 21 – Third (final) request**

*If the missing items are not received, the case will be placed in the "Canceled – Incomplete Submission" status. Once in this status, it cannot be reopened, and a new application must be completed.*

# PROVIDER ENROLLMENT REMINDERS

## Recredentialing

- Recredentialing occurs every three years.
- Our credentialing team makes outreach when the provider's recredentialing date is approaching.
  - First, they call to see if the provider is actively working at the location on file.
    - If no response is received after the first attempt, a second attempt is made in **14 days**.
    - If no response is received after the second attempt, a third attempt is made in **seven days**.
    - If no response is received after the third (final) attempt, the status change process begins.
- If the recredentialing date is missed, the provider is termed, and new enrollment is required.

*Note: Be sure the credentialing contact email address is current as this is what's used for outreach.*

# PROVIDER ENROLLMENT REMINDERS

## Non-credentialed Providers

Acupuncturists

Associate  
Counselors

Christian  
Science  
Practitioners

Diabetes  
Education

Dieticians\*

Education  
Specialists

Homeopaths

Lay Midwives

Massage  
Therapists

Naturopaths

Occupational  
Therapy  
Assistants

Physical  
Therapy  
Assistants

Psychology  
Assistants

Recreational  
Therapists

School  
Psychologists

Sports Trainers

Technicians

*Note: This list may not be all inclusive.*

*\*Can join the Healthy Blue network.*

# PROVIDER ENROLLMENT REMINDERS

## Provider Directory Validation

As of **Jan. 1, 2022**, providers are required to verify their demographic data at least **every 90 days**. Our provider directory team also makes outreach every 90 days to ensure validation.

***Note: Be sure the credentialing contact email address is current as this is what's used for outreach.***

## *Importance of Validation*

- Allows us to maintain accurate directories
- Ensures members know where to find you

## *How to Validate Information*

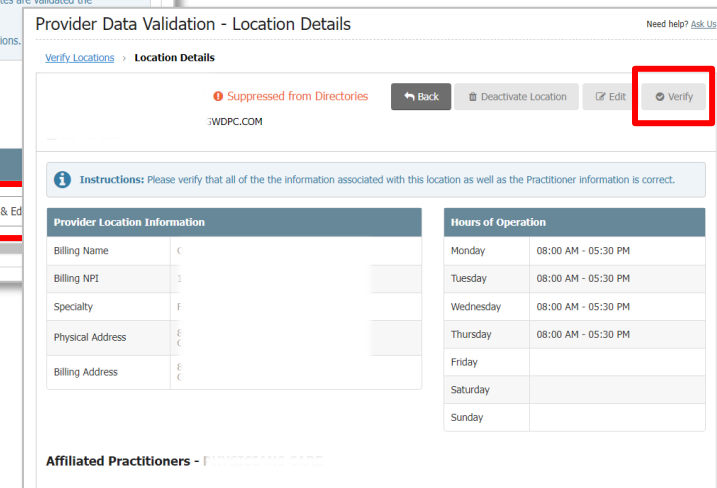
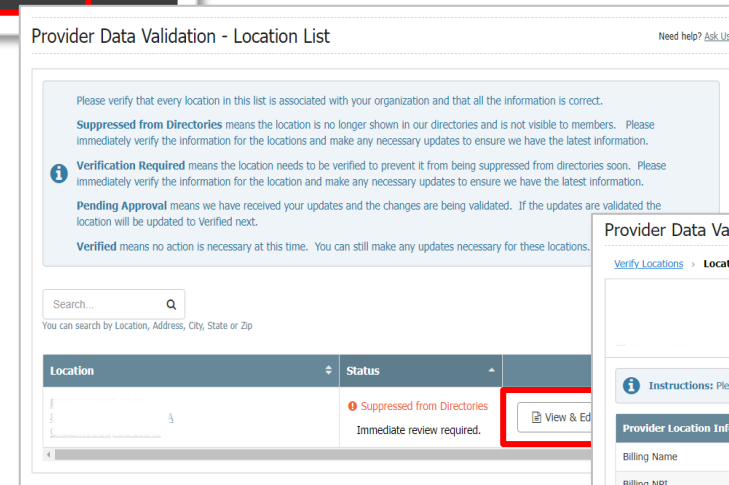
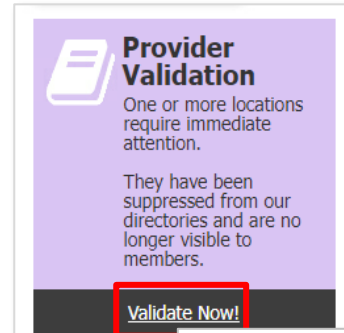
- M.D. Checkup

# PROVIDER ENROLLMENT REMINDERS

## Provider Directory Validation (Continued)

*Has your location been suppressed?*

- Locations are suppressed in the provider directory if more than 90 days has passed since the last validation was made, per the CAA guidelines.
- To have the suppressed status updated, the group administrator should:
  - Log into My Insurance Manager<sup>SM</sup>
  - Select Validate Now in the Provider Validation box
  - Select View and Edit from the location(s) listed
  - Review the information, make the necessary updates, if needed, and select Verify



# PROVIDER ENROLLMENT REMINDERS

## Provider Updates – My Provider Enrollment Portal

The following updates can be made using My Provider Enrollment Portal

- Business name change
  - Using the Doing Business As (DBA) Name Change form
- Address change
  - Using the Change of Address form
- NPI update
  - Using the NPI Provider Notification form
- Adding a location
  - Using the Application for Satellite Location form
- Adding or terminating practitioner affiliation
  - Using the Add or Terminate Practitioner Affiliation form





# PROVIDER ENROLLMENT REMINDERS

## Provider Updates – M.D. Checkup

### *What is M.D. Checkup?*

- Web-based tool used for provider demographic updates
- M.D. Checkup is accessible through My Insurance Manager

The following updates can be made through M.D. Checkup:

- Business name change
- Address change
- Adding or terminating a location
- Adding or terminating a practitioner affiliation
  - You can only add a practitioner in M.D. checkup if they are enrolled and associated with the tax identification number.



# PROVIDER ENROLLMENT REMINDERS

## M.D. Checkup – Removing Locations



A screenshot of the "Provider Data Validation - Locations List" interface. At the top, there is a navigation bar with links for Home, Patient Care, Office Management, Resources, Modify Profile, Profile Administration, Staff Directory, and Provider Update. Below the navigation bar, the page title "Provider Data Validation - Locations List" is displayed. A search bar is present with the text "Search locations..." and a note: "You can search by Location, Address, City, State or Zip". A table lists three locations: "Provider 1 Main Street", "Provider 2 Pine Road", and "Provider 3 Davis Avenue". Each location has a "Requires Verification" status and "View &amp; Edit" and "Remove Location" buttons.

A close-up of two buttons: "View &amp; Edit" and "Remove Location". The "View &amp; Edit" button features a document icon, and the "Remove Location" button features a trash can icon.

A screenshot of the "Request to Remove Location" dialog box. The title is "Request to Remove Location". The text asks: "Are you sure you wish to remove Palmetto Northeast? Please enter the date on which you want this location to be removed." A note states: "Note: The removal date must be after the original effective date." There is a date input field with a calendar icon and a "Remove" button. A "Cancel" button is also visible.

**DO NOT** use this function to remove a location from your VIEW!

# PROVIDER ENROLLMENT REMINDERS

## M.D. Checkup – Adding Practitioner Affiliations

To add a practitioner affiliation through M.D. Checkup:

- The practitioner must be enrolled and associated with the tax identification number (TIN).
  - Submit the Add/Terminate Practitioner Affiliation form to add a practitioner to a location under a different TIN.

### Example:

- *TIN A – 123456789*
  - Location 1
  - Location 2
- *TIN B – 987654321*

Dr. Tommy Pickles **is associated** with TIN A and works at Location 1. He can be added to Location 2 through M.D. Checkup.

Dr. Tommy Pickles **is not associated** with TIN B. To be added to this location, the Add/Terminate Practitioner Affiliation form must be submitted.





# **MY PROVIDER ENROLLMENT PORTAL OVERVIEW**



# MY PROVIDER ENROLLMENT PORTAL OVERVIEW

## Use the portal to:

- Become a network provider.
- Receive automated status updates.
- Make certain updates for the physician or practice.
- Receive notifications when additional information is needed.

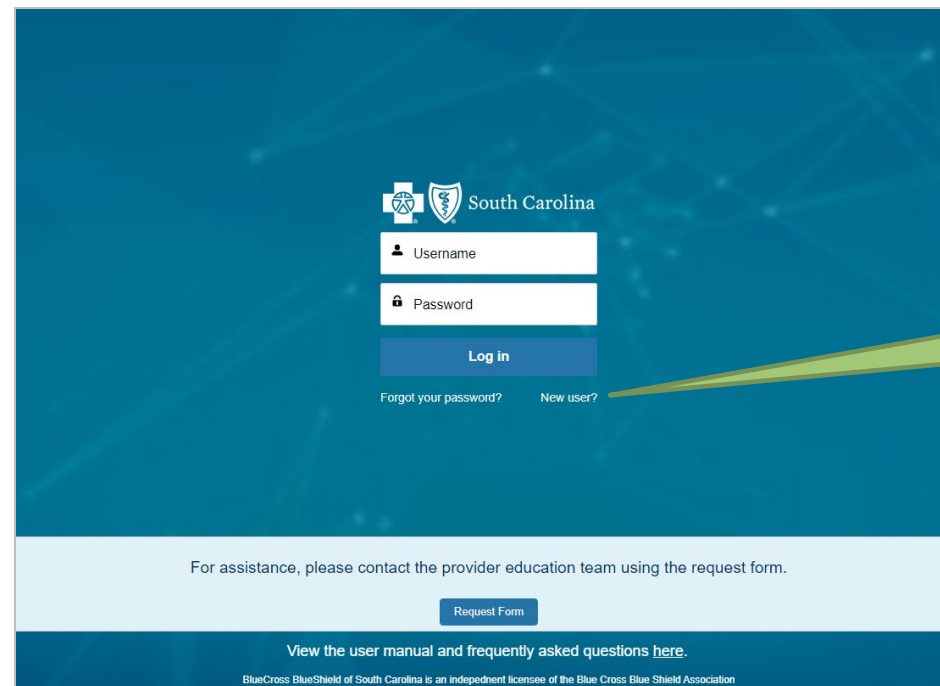


# MY PROVIDER ENROLLMENT PORTAL OVERVIEW

## Sign Up for Access to the Portal

Visit [www.SouthCarolinaBlues.com](http://www.SouthCarolinaBlues.com)

*Providers>Provider Enrollment>My Provider Enrollment Portal*

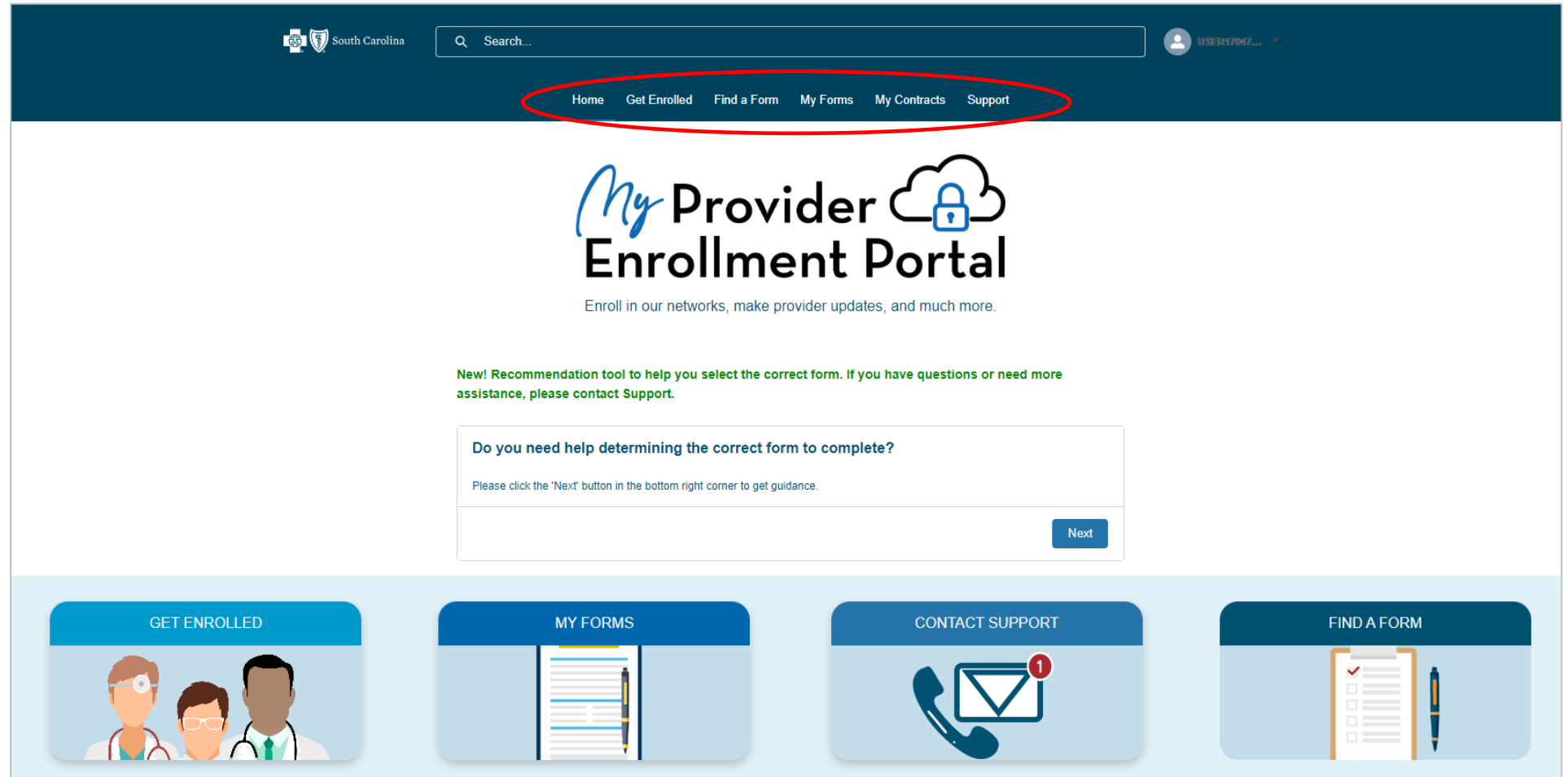


The screenshot shows the login page for the South Carolina Blues provider enrollment portal. The page has a dark blue background with a light blue footer. At the top center, there is a logo for South Carolina Blues, which includes a cross and a shield. Below the logo are two input fields: 'Username' and 'Password'. A blue 'Log in' button is positioned below the password field. Underneath the 'Log in' button are two links: 'Forgot your password?' and 'New user?'. A green callout bubble points to the 'New user?' link. At the bottom of the page, there is a light blue bar with the text 'For assistance, please contact the provider education team using the request form.' and a blue 'Request Form' button. Below this bar is a dark blue footer with the text 'View the user manual and frequently asked questions [here](#).' and a small line of text at the very bottom: 'BlueCross BlueShield of South Carolina is an independent licensee of the Blue Cross Blue Shield Association'.

Select New user if you've never signed up!

# MY PROVIDER ENROLLMENT PORTAL OVERVIEW

## Home Page



The screenshot displays the home page of the My Provider Enrollment Portal. At the top, there is a dark blue header with the South Carolina state logo and name on the left, a search bar in the center, and a user profile icon with the text 'USER17047...' on the right. Below the header is a navigation menu with the following items: Home, Get Enrolled, Find a Form, My Forms, My Contracts, and Support. The 'Home' link is circled in red. The main content area features the portal's logo, 'My Provider Enrollment Portal', with a padlock icon inside a cloud. Below the logo is the text 'Enroll in our networks, make provider updates, and much more.' A green announcement states: 'New! Recommendation tool to help you select the correct form. If you have questions or need more assistance, please contact Support.' Below this is a white box with the question 'Do you need help determining the correct form to complete?' and the instruction 'Please click the 'Next' button in the bottom right corner to get guidance.' A blue 'Next' button is located at the bottom right of this box. At the bottom of the page, there are four light blue tiles with dark blue headers: 'GET ENROLLED' (with an icon of three healthcare providers), 'MY FORMS' (with an icon of a document and a pen), 'CONTACT SUPPORT' (with an icon of a telephone and an envelope with a red '1' notification), and 'FIND A FORM' (with an icon of a checklist and a pen).

# MY PROVIDER ENROLLMENT PORTAL OVERVIEW

## Get Enrolled

**Get Enrolled...**  
Looking to join one of our networks? Select one of the appropriate forms below to get started. Review the [available checklists](#) to ensure all required documents are included.

**Individual Provider Enrollment**

For Providers wanting to enroll with BlueCross BlueShield of South Carolina and BlueChoice HealthPlan.

**Note:** This application applies to medical, dental, and mid-level providers. This application does NOT apply to Behavioral Health providers.

[ENROLL](#)

**Group Practice Enrollment**

For group practices wanting to enroll with BlueCross BlueShield of South Carolina and BlueChoice HealthPlan.

**Note:** Complete this form to notify BlueCross BlueShield of South Carolina and BlueChoice HealthPlan of the creation of a new location that wishes to file claims.

[ENROLL](#)

**Facility Information Request Form**

Complete this form to request the credentialing of a facility.

Note: This form is for...

**Virtual Care Services**

For providers or group practices wanting to participate with telemedicine and/or telehealth services.

**Health Professional Application**

Complete this form to request the addition of a health professional to our database to enable that practitioner to file

**For Behavioral Health Providers**

**Behavioral Health**

For providers wanting to enroll in our behavioral health network.

**Note:** Companion Benefit Alternatives, Inc. (CBA) manages our behavioral health network. CBA is a separate company that administers behavioral health benefits on behalf of BlueCross BlueShield of South Carolina.

[ENROLL](#)

**Autism Provider Panel**

For Applied Behavior Analysts wanting to enroll in our Autism Provider Panel

**Note:** Companion Benefit Alternatives, Inc. (CBA) manages our Autism provider panel. CBA is a separate company that administers behavioral health benefits on behalf of BlueCross Blue Shield of South Carolina.

[ENROLL](#)

### Individual Checklist

Checklist Items	Advanced Practice Provider	Physician	DDS	DMD	Ancillary	Chiro	Pharmacist
Provider Enrollment Application	✓	✓	✓	✓	✓	✓	✓
Copy of SC Medical or Practice License	✓	✓	✓	✓	✓	✓	✓
Drug Enforcement Administration (DEA) Certification*	Footnote 1	✓	✓	✓			✓
Current Copy of Malpractice (Min. \$1M/\$3M)		✓	✓	✓	✓	✓	Footnote 6
Authorization to Bill for Services	✓	✓	✓	✓	✓	✓	✓
Nurse Practitioner Preceptor Form	Footnote 2						
Protocols (Written Agreement)	Footnote 2						
Signed Contracts	✓	✓	Footnote 4	Footnote 5	✓	✓	✓

- Hold Harmless\*\*
  - Appendix D\*\*
  - Professional Training\*\*\*
  - Medicaid ID Number\*\*\*\*
- \*Only if applicable.  
 \*\*Only if applying for BlueChoice  
 \*\*\*Required for MDs, DOs and D  
 \*\*\*\*Only if applying for Healthy B

### Group Practice Checklist

Checklist Items	Physician Office	Ambulance	DME	Home Health, Hospice, Dialysis, Hospitals, Skilled Nursing, ASC	Pharmacy	Dental
Group Practice Application	✓	✓	✓	✓	✓	✓
IRS Verification of Tax ID (Letter 147C or CP 575E)	✓	✓	✓	✓	✓	✓
Electronic Funds Transfer Enrollment	✓	✓	✓	✓	✓	✓
Signed Contracts	✓	✓	✓	✓	✓	Footnote 2
Copy of CMS Letter		✓	Footnote 1	✓	Footnote 1	
Copy of Business License			✓	✓		
Copy of DHEC License				✓	✓	
Medicaid ID Number*	✓	✓	✓	✓	✓	✓
Copy of NPPES NPI Notification	✓	✓	✓	✓	✓	✓
Add Practitioner Forms**	✓	✓	✓			✓

\*Only if applying for Healthy Blue™.

\*\*For each physician being added to the group. This form does not generate with the group application. It is under the Find a Form section of the portal. Note: If the provider is not credentialed, you must complete the Provider Enrollment application.

<sup>1</sup>CMS letter must include Medicare PTAN.

<sup>2</sup>For oral surgeons applying for BlueChoice and Healthy Blue. All other contracts depend on the individual physician's credentialing status.



# MY PROVIDER ENROLLMENT PORTAL OVERVIEW

## Find a Form

### Find a Form

Use the following forms for other enrollment options or to provide additional information to BlueCross BlueShield of South Carolina

Do you need help determining the correct form to complete?

Please click the 'Next' button in the bottom right corner to get guidance.

Next

### Update Location Information

#### Doing Business As (DBA) Name Change Form

Complete this form to change your doing business as (DBA) name.

COMPLETE FORM

#### Change of Address Form

Use this form to update your physical, pay to, correspondence and/or billing agency addresses for Preferred Blue®, BlueChoice HealthPlan, Healthy BlueSM, State Health Plan, and FEP networks.

**Note: If you are changing a pay to address, the provider or the CEO, CFO, director of finance, or director of billing must sign this form for your protection.**

COMPLETE FORM

#### Application for Satellite Location

Complete this form to notify BlueCross BlueShield of South Carolina and BlueChoice HealthPlan of the creation of a new location that wants to file claims.

**Note: A W-9 cannot be accepted.**

COMPLETE FORM

### Update Provider Information

#### NPI Provider Notification Form

Register your National Provider Identifier (NPI) with BlueCross BlueShield of South Carolina and BlueChoice HealthPlan using this form. If you registered for more than one NPI, complete this form for each NPI.

Attach your notification letter from the National Plan and Provider Enumeration System (NPPES) for each NPI you received. This verification is required.

**Note: This form is for out-of-state and out-of-network providers only.**

COMPLETE FORM

#### Add or Terminate Practitioner Affiliation

Please complete this form to request the addition or termination of a health professional's association with your clinic, group, professional association, or institution for BlueCross BlueShield of South Carolina for Preferred Blue®, BlueChoice HealthPlan, Healthy BlueSM, FEP and/or State Health Plan.

**Note: This form should be completed no more than 30 days after the addition, termination or change.**

COMPLETE FORM

# MY PROVIDER ENROLLMENT PORTAL OVERVIEW

## My Forms

### My Forms

Complete forms that have been started or check the status of applications already submitted.

- **In Progress/Not Submitted** – The application or form is being worked by the provider or their practice. It has not been completed for submission.
- **Submitted** – The application and **all required documentation with applicable signatures, initials, and dates** have been uploaded.
- **Awaiting Signature/Not Submitted** – The application or form has been completed and submitted, **but signatures are missing**.
- **Awaiting Provider Response** – Missing items are needed from the provider or their practice to continue the enrollment process. You will receive an email and case comment explaining what item(s) is needed.
- **Under Review** – The application or form has been assigned and has progressed through the enrollment process.
- **Congratulations! Complete** – The application or form has been approved and completed.
- **Denied** – The application or form was not approved. An explanation for the denial is sent through email or case comment.
- **Canceled** – The application or form is no longer being worked on and has been closed.

If your case is in the status of **Awaiting Signature**, click the case number to view next steps.

All Applications ▾ 🔍

50 items • Sorted by Date/Time Opened • Filtered by All cases

	Case Number ▾	Practitioner Last... ▾	Status ▾	Form Type ▾	Date/Time Opened ↓ ▾	
1	00022086		In Progress/Not Submitted	Individual Application	4/2/2024, 1:36 PM	▾
2	00022085		In Progress/Not Submitted	NPI Update	4/2/2024, 1:29 PM	▾
3	00022084		In Progress/Not Submitted	NPI Update	4/2/2024, 1:29 PM	▾
4	00022081		In Progress/Not Submitted	Change of Address	4/1/2024, 5:40 PM	▾
5	00022080		In Progress/Not Submitted	Individual Application	4/1/2024, 3:35 PM	▾
6	00022079	Freeman	Awaiting Signature/Not Submitted	Individual Application	4/1/2024, 12:57 PM	▾

All Applications ▾ 🔍

#### LIST VIEWS

- ✓ All Applications (Pinned list)
- Applications Awaiting Provider Response
- Approved Applications
- Denied Applications
- Open Applications
- Recently Viewed
- Recently Viewed Cases
- Recredentialing - Awaiting Response
- Submitted Applications

# MY PROVIDER ENROLLMENT PORTAL OVERVIEW

## My Contracts

### My Contracts

Complete contracts that require your attention or check their status.

All Contracts ▾



4 items • Sorted by Case • Filtered by All form contracts - Status



	Case ↑ ▾	Status ▾	Form Contract ... ▾	Network List ▾	Form Type ▾	Last Modified Date ▾	
1	00030455	Awaiting Signature	FCR-12433	Blue Essentials	Individual Application	8/4/2023, 7:28 PM	▾
2	00030455	Awaiting Signature	FCR-12434	Medicare Advantage	Individual Application	8/4/2023, 7:28 PM	▾
3	00030455	Awaiting Signature	FCR-12436	State Health Plan	Individual Application	8/4/2023, 7:28 PM	▾
4	00030455	Awaiting Signature	FCR-12435	Preferred Blue® (PPC and FEP)	Individual Application	8/4/2023, 7:28 PM	▾

# MY PROVIDER ENROLLMENT PORTAL OVERVIEW

## Support

### CONTACT PROVIDER SUPPORT

Complete the below support form for questions regarding correct applications and forms to use OR if after checking the directory you do not see a provider that should be loaded.

*Note: For behavioral health providers, please include the provider's specialty in the description box.*

\*FULL NAME

\*EMAILADDRESS ⓘ

\*INDIVIDUAL NPI ⓘ

GROUP NPI

TAX ID NUMBER ⓘ

ROLE

RELATED CASE NUMBER(S) ⓘ

\*SUBJECT ⓘ

\*DESCRIPTION ⓘ

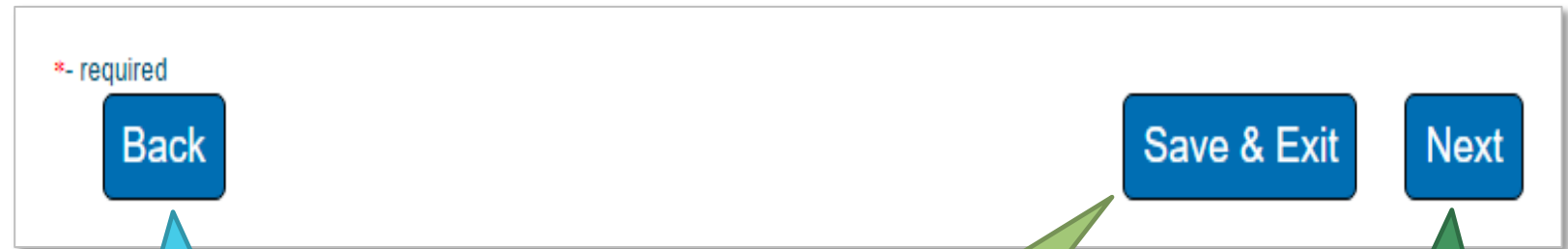
SUBMIT

For assistance, please contact the provider education team using the [request form](#).

# MY PROVIDER ENROLLMENT PORTAL OVERVIEW

## Navigation

### *Navigational buttons*

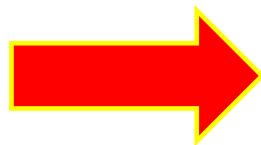


Use the Back button to move backwards in the application or form.

Use the Save & Exit button to save the entered data and exit the application or form.

Use the Next button to move forward in the application or form.

When you get here, you MUST select Next to submit the application.



< You are almost done. See instructions below to complete your application. >

**You are almost done. See instructions below to complete your application.**

# MY PROVIDER ENROLLMENT PORTAL OVERVIEW

## Next Steps for Medical Documents That **Must be Signed.**

### Thank you

To complete your submission, go to the documents section under Form Information. Download your application, print, apply your signature, and re-upload them using the Upload Files button. Please note that your downloadable application will take a few minutes to appear.

#### Please note that:

1. You can always find your files under the "My Forms" section. Make note of your case number for easy access.
2. If contracts are required, they will be found in the "My Contracts" section with the reference to your case number.
3. If you need assistance, use the communication case comment section in this case. This way both you and your representative will have all the information and questions in one location.

### *For applications and forms (Electronic or wet signature)*

1. Select My Forms
2. Select the appropriate case number
3. Select Form Information
4. Under Documents, select the document(s) that require signature
5. Download the document(s) and have the signature(s) appended
6. Scan the signed documents and follow steps 1 – 4 and select Upload Files
7. Select the Confirm button to attest that **all required documentation with applicable signatures, initials and dates** have been uploaded

### *For contracts (Wet signature)*

1. Select My Contracts
2. Select the appropriate form contract name that corresponds with your case number
3. Under Download Contract, select the link to download and sign the contract
4. Follow steps 1 – 2 and select Upload Files

# MY PROVIDER ENROLLMENT PORTAL OVERVIEW

## Next Steps for Behavioral Health Documents That **Must be Signed (CBA).**

### Thank you for your submission!

There are two options to sign and return applications/documents. They can be **wet signed** or they can be **e-signed**.

#### Signatures for Applications/Documents

An email will be sent to the individual practitioner for signature of their enrollment application allowing them to e-sign the application. However, as the credentialing contact, you also have the option to download the application, have the individual practitioner sign the application and upload the signed application to the case. See steps listed below. As the credentialing contact, you will receive a copy of the signed application.

For other documents and forms, if you wish to e-sign, an email will be sent from BCBS Admin at BCBS of SC (Formstack) requesting signatures. Once e-signed and submitted, we will receive your signed documents and begin processing your request. (Note: you will also receive an email containing the signed documents for your records.)

If you wish to wet sign the application/document, please see the instructions below.

1. Select "My Forms" from the MyPep options
2. Select the appropriate case number
3. Select Form Information
4. Under Documents at the bottom of the page, select the application/document requiring signature
5. Select Download at the top of the page
6. Print and sign the application/document
7. To upload the signed application/document, follow steps 1 and 2 above and click on Upload Files

#### Signatures for Contracts

Contractual agreements may be e-signed or wet signed. Wet signed documents are required to be downloaded, signed, and uploaded into the MyPep Tool. To submit signed contracts, please see these instructions.

1. Select "My Contracts" from the MyPep options
2. Sort on "All Contracts"
3. Locate your case number and click on corresponding "Form Contract Name"
4. This will take you to a page containing a link to the document.
5. Print and sign the document. Save the signed document to your computer.
6. To upload the signed document, follow steps 1 and 2 above and click on Upload Files.

### *For applications (if wet signing)*

1. Select My Forms
2. Select the appropriate case number
3. Select Form Information
4. Under Documents, select the document(s) that require signature
5. Download the document(s) and have the signature(s) appended
6. Scan the signed documents and follow steps 1 – 4 and select Upload Files
7. Select the Confirm button to attest that **all required documentation with applicable signatures, initials and dates** have been uploaded

### *For contracts (if wet signing)*

1. Select My Contracts
2. Select the appropriate form contract name that corresponds with your case number
3. Under Download Contract, select the link to download and sign the contract
4. Follow steps 1 – 2 and select Upload Files

# MY PROVIDER ENROLLMENT PORTAL OVERVIEW

## Next Steps for Documents That Do Not Have to be Signed.

### Thank you

Please note that:

1. You can always find your files under the "My Forms" section. Make note of your case number for easy access.
2. If you need assistance, use the communication case comment section in this case. This way both you and your representative will have all the information and questions in one location.

### ***Includes:***

- NPI Provider Notification form
- Satellite Location application
- Virtual Care application



# MY PROVIDER ENROLLMENT PORTAL OVERVIEW

## Confirmation Button – Provider Attestation

FORM **FORM INFORMATION**

Application Status: <a href="#">Awaiting Signature</a>	Application Type: <a href="#">Individual Application</a>	Case Number: <a href="#">00016466</a>	Date Received: <a href="#">March 8, 2023</a>
Contact Name: <a href="#">Terrence Fleming</a>	Practitioner Name: <a href="#">Donald Duck</a>	Networks Chosen: <a href="#">Blue Essentials</a>	

Please wait for at least five minutes for the PDF files to generate.

You confirm that all required documents have been completed appropriately; all applications, associated forms, and contracting documents have been signed and/or initialed and dated (with current date) as indicated on these documents, and the required information/documentation and signed forms have been uploaded to the case.

Confirm

Thank you for uploading your documents.

Only select this button AFTER the documents have generated and all required items have been uploaded.

# MY PROVIDER ENROLLMENT PORTAL OVERVIEW

## Important Items in the Portal

- Case numbers
- Statuses
- Contracts
- Case comments

# MY PROVIDER ENROLLMENT PORTAL OVERVIEW

## Case numbers

Generated with each application, form and support case.

**My Forms**  
Complete forms that have been started or checked

All Applications ▾

1 item • Sorted by Case Number • Filtered by All cases

Case Number ↑	
1	00001796

## Case numbers are used for:

- Checking statuses
- Submitting case comments
- Uploading provider contracts

# MY PROVIDER ENROLLMENT PORTAL OVERVIEW

## Statuses

Changes as the application or form progresses.

**My Forms**  
Complete forms that have been started or check the status of applications already submitted.

All Applications ▼ ↑

1 item • Sorted by Case Number • Filtered by All cases

	Case Number ↑	Practitioner Last Name	Status
1	00001796		In Progress

## Statuses include:

- In Progress/Not Submitted
- Submitted
- Awaiting Signature/Not Submitted
- Awaiting Provider Response
- Under Review
- Congratulations! Complete
- Denied
- Canceled

# MY PROVIDER ENROLLMENT PORTAL OVERVIEW

## In progress/Not Submitted

The application or form is being worked by the provider or their practice. It has not been completed for submission.

## Submitted

The application and **all required documentation with applicable signatures, initials and dates** have been uploaded.

## Awaiting signature/Not Submitted

The application or form has been completed and submitted, **but signatures are missing.**

## Awaiting provider response

Missing items are needed to continue the credentialing process.

# MY PROVIDER ENROLLMENT PORTAL OVERVIEW

Under review

The application or form has been assigned and has progressed through the credentialing process.

Congratulations! Complete

The application or form has been approved.

Denied

The application or form was not approved.  
*Note: Explanation for the denial is sent through email or case comment.*

Canceled

The application or form is no longer being worked and has been closed.

# MY PROVIDER ENROLLMENT PORTAL OVERVIEW

## Contracts

Provided during the application review process.

**My Contracts**  
Complete contracts that require your attention or check their status.

All Contracts ▾

1 item • Sorted by Form Contract Name • Filtered by All form contracts - Status

	Form Contract Name ↑ ▾	Chosen Network ▾	Case ▾	Status
1	FCR-0521	BlueChoice HealthPlan	00001753	Awaiting Signature

## Steps for contracts:

1. Download the contract(s)
2. Print the contract(s)
3. Have the practitioner sign the contract(s) in ink
4. Upload the signed contract(s) to the appropriate case

*Note: Behavioral health contracts can be signed electronically.*

# MY PROVIDER ENROLLMENT PORTAL OVERVIEW

Case comments

Use for case specific questions (applications and forms).

The screenshot displays the 'COMMUNICATION' section of the portal. A red circle highlights the 'Case Comments (0)' link. Below this, the 'APPLICATION INFO' section is visible, showing details for 'Application Information' such as Case Number (00001706), Contact Name (Terrence Archie), Form Type (Provider Services), Status (Awaiting Signature), Date Received (2/28/2022), Description, and Subject. A 'New' button is shown in a callout box, and a 'New Case Comment' modal is open, featuring a text area for the comment body, checkboxes for 'Public' and 'Send Customer Notification', and 'Cancel' and 'Save' buttons.

## Steps for case comments:

1. Select Case Comments
2. Select New
3. Enter your comment or question in the body
4. Select Save





# **COMPLETING A CLEAN APPLICATION**



# COMPLETING A CLEAN APPLICATION

## Steps to Submitting a Clean Application

1. Complete the enrollment application inside My Provider Enrollment Portal.
2. Download, print and sign (include signatures, initials and dates) the application and authorization to bill.
  - Documents will be listed under Form Information.
3. Upload the signed documents back to the case.
  - Select My Forms.
  - Select the case number.
  - Select Form Information.
  - Select Upload Files.
4. Download, print and sign (include signatures and dates) all applicable contracts.
5. Upload the signed contracts to the case.

Checklist Items
Provider Enrollment Application
Copy of SC Medical or Practice License
Drug Enforcement Administration (DEA) Certification*
Current Copy of Malpractice (Min. \$1M/\$3M)
Authorization to Bill for Services
Signed Contracts
Professional Training**
Hold Harmless***
Appendix D***
Medicaid ID Number****

Start with the appropriate checklist.

Initial Enrollment Information Applicant Information Medical/Professional Ed >

### Initial Enrollment Information

**Network(s) Selection**

Networks in which you are requesting to participate (Select all that apply).  
 If you select the Healthy Blue network, you **MUST** provide the Individual Medicaid ID # at the time of submission for this case.

If you currently **do not have the Medicaid ID#**, please choose one of the two options below for your next step for this enrollment:

1: You will hold the application for all network(s) credentialing to be processed at one time by clicking "Save and Exit." This will save what you have completed to this point, and you can return to submit the application once you have received the Medicaid ID#.

2: You will move forward with the enrollment excluding the Healthy Blue Network on this application. Once the Medicaid ID # is received, you will submit a new separate case for that network only.

**\*\*Please be mindful we WILL NOT combine the cases of the submitted information if option #2 is chosen.\*\***

**Networks**  
 To select multiples: Please hold control key and click the network(s).  
 \*

- Blue Essentials
- Blue Option<sup>SM</sup>
- BlueChoice HealthPlan
- Healthy Blue<sup>SM</sup>
- Medicare Advantage

You are acknowledging that the Healthy Blue network is being excluded from this provider enrollment application intentionally. You are aware that if the Healthy Blue network participation is needed, a new separate Case is required to be submitted.

Healthy Blue Acknowledgement\*  
 --select an item--

**Contact Information**

Credentialing Contact First Name\*

Credentialing Contact Last Name\*

Credentialing Contact Role\*  
 --select an item--

Credentialing Contact Email\*

Credentialing Contact Phone\*

Preferred Method of Contact\*  
 --select an item--

# Provider Enrollment Application

**Applicant Information** Medical/Professional Education Professional Training L >

## Applicant Information

First Name\*

Angelica

Last Name\*

Pickles

Middle Initial

Suffix

Maiden Name

Gender(optional): M/F

--select an item--

Race\*

White

Ethnicity\*

Not Hispanic or Latino

Title (if applicable)

Provider's License Type\*

Physician

Professional Designation\*

MD

Social Security #\*

001122334

National Provider ID#\*

9632587410

Birth Date (MM/DD/YYYY)\*

02/01/1987

Provider Email Address\*

angelica.pickles@abctesting.com

ECFMG # (if applicable)

What date will this provider start working for your practice (MM/DD/YYYY)\*

11/13/2023

Language(s) Spoken (other than English)\*

× English

What language services are offered through your practice?\*

× Telephone

## Area(s) of Specialty

Primary\*

DERMATOLOGY

Include in Directory

Sub-Specialty

--select an item--

Include in Directory

Primary Taxonomy\*

229N00000X

Provider Type\*

Specialist

Must match  
Authorization to Bill.

Save & Exit

Next

## Provider Enrollment Application

**Medical/Professional Education** Professional Training License(s) Speciality E >

### Medical/Professional Education

Name of School\*

Clemson University

Start Date (MM/DD/YYYY)\*

08/08/2005

Graduation Date (MM/DD/YYYY)\*

12/16/2013

Country\*

United States

City\*

Clemson

State\*

SC

Degree\*

Doctorate

+ add item

\* - required

Back

Save & Exit

Next

## Provider Enrollment Application

< **Professional Training** License(s) Speciality Board Certification Hospital Privile >

### Professional Training

Have you had Cultural Competency Training?\*

No

Date Completed (Cultural Competency) (MM/DD/YYYY)

Do you have professional training to add?\*

Yes

Training Institution\*

Learn to Help

Program\*

Residency

Country

United States

City\*

Florence

State\*

SC

Program Completed\*

Yes

Start Date (MM/DD/YYYY)\*

01/06/2014

Completion Date (MM/DD/YYYY)\*

10/17/2016

+ add item

DOs, DPMs and MDs must have a minimum of residency training for credentialing.

## Provider Enrollment Application

< **License(s)** Speciality Board Certification Hospital Privileges Work History Offi >

### License(s)

Active?



State\*

SC

License #\*

911119

Issue Date (MM/DD/YYYY)\*

01/14/2015

Expiration Date (MM/DD/YYYY)

01/14/2024

[+ add item](#)

***\*Upload a copy of your Active State License.***

State License Upload\*

Add File...

✖ State License Example.docx

### Federal DEA

Do you currently hold a federal DEA registration in each State you prescribe controlled substances?\*

Yes

*If DEA app has been submitted and is PENDING, DDS will not write prescriptions until DEA is finalized.*

DEA License File\*

Add File...

✖ DEA Example.docx

**Licenses must be active on or before the requested start date for the practice.**

## Provider Enrollment Application

< **Speciality Board Certification** Hospital Privileges Work History Office Practic >

### Speciality Board Certification

Are you board certified?\*

No



+ add item

If not certified, are you qualified to sit for the examination?

--select an item--



If you select Yes, additional details are required.



## Provider Enrollment Application

< **Hospital Privileges** Work History Office Practice Information Electronic Claim >

### Hospital Privileges

Do you have privileges at any hospital facility?\*

Yes

If no please describe arrangements for hospital care:

Hospital\*

Prisma Health

Department\*

Outpatient

Street\*

1300 Taylor Street

City\*

Columbia

State\*

SC

Zip Code\*

29201

Status of Privileges\*

Active

Affiliation From Date (MM/DD/YYYY) \*

04/11/2018

Affiliation To Date (MM/DD/YYYY)

% Admissions\*

100

+ add item

Admissions must total 100%. If there are multiple privileges, the TOTAL should be 100 combined, not separately.

## Provider Enrollment Application

< **Work History** Office Practice Information Electronic Claim Filing Requirement | >

### Work History

Please enter your current or most recent employer first.  
To enter a future employer, ensure the Current checkbox is checked.

Current



Name of Previous/ Current Employer\*

ABC Help

From Date (MM/DD/YYYY)\*

01/16/2017

+ add item

Explanation of gaps in work history

Be sure to select the 'Current' box if the provider is currently working for the practice. Additionally, if their work history does not cover five years, please include an explanation.

# Provider Enrollment Application

< Office Practice Information Electronic Cla

## Office Practice Information

### Primary Site

Office practice name\*

Healthy Hearts

Office e-mail\*

healthyhearts@gmail.com

Practice Website

### Physical Office Location

Physical Office Location (address) Should the Provider display in the Dire

Yes

Street\*

5516 Augusta Drive

City\*

Columbia

State\*

SC

Zip Code\*

29219

Appointment Phone\*

803-586-0001

County\*

Richland

### Contact Information

Office Contact First Name\*

Tony

Office Contact Last Name\*

Bennett

Phone #\*

803-586-0002

Email\*

tony.bennett@help.com

Credentialing contact same as office contact?

Credentialing Contact First Name\*

Tony

Credentialing Contact Last Name\*

Bennett

Phone #\*

803-586-0002

Email\*

tony.bennett@help.com

## Group Information

Group EIN/TIN#\*

01478521

Group NPI#\*

9856324105

Group Medicare #

Has your group signed agreement to participate with Medicare in the past twelve months?

--select an item--

Bill for laboratory services at office?\*

Yes

Current CLIA certification?\*

Yes

CLIA Certification Number\*

AB987654

Handicap access\*

Yes

Is your office equipped with telecommunication devices for the deaf?

--select an item--

Does your office offer 24/7 coverage? (Y/N and Description)\*

No

Please describe (if No, please explain)\*

Triage system.

Is sign language assistance available?

--select an item--

Languages Spoken by staff\*

English

## Billing Address

Billing Address Same as Office Location



Name claims payable to\*

Healthy Hearts

Street/PO\*

5516 Augusta Drive

City\*

Columbia

State\*

SC

Zip code\*

29219

Billing Phone #\*

803-586-0001

Billing Fax

## Mailing Address

Mailing Address Same as Office Location?



## Provider Patient Population

Does this provider see patients at this location?\*

No

Do you accept Medicaid patients?\*

No

*If you have applied, your application will be pending until your Medicaid ID number has been received.*

Individual Medicaid #

Are there patient age limitations?\*

No

Are there patient gender restrictions?\*

No Restrictions

Please describe any other patient limitations

## Additional Location

Additional Location Needed

--select an item--

## Provider Enrollment Application

[< Provider Disclosure Information](#) [Malpractice Insurance](#) [Auth to Bill](#) [You are >](#)

### Provider Disclosure Information

*If you are filling out this application on behalf of a provider, please skip this section. This section must be completed by the provider.*

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

1. Do you have any pending misdemeanor or felony charges?\*

No

2. Have you ever been convicted of a felony?\*

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?\*

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?\*

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?\*

No

6. Have you ever been publicly reprimanded or disciplined by a professional licensing agency or board?\*

No

7. Has your DEA certification or state-controlled drug permit ever been restricted, suspended, revoked, voluntarily relinquished or otherwise limited?\*

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?\*

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?\*

No

10. Has your participation in an Insurance Company network ever been limited or terminated?\*

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?\*

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?\*

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?\*

No

14. Has your professional liability insurer ever placed conditions or restrictions on your coverage or ability to obtain coverage?\*

No

## Provider Enrollment Application

< **Malpractice Insurance** Auth to Bill You are almost done. See instructions below >

### Malpractice Insurance

#### Malpractice Insurance

Carrier's Name\*

You're Covered, LLC

Policy Number\*

911

Street\*

1563 Ohio Street

City\*

Columbia

State\*

SC

Zip\*

29203

Effective Date (MM/DD/YYYY)\*

04/15/2019

Expiration Date (MM/DD/YYYY)\*

04/15/2024

*Additional coverage will be needed if the minimum coverage requirements are not met. Minimum coverage for mid-levels is \$1 mil / \$1 mil. Minimum coverage for all others is \$1 mil / \$3 mil.*

Amount of Coverage (Each occurrence)\*

\$1 million

Amount of Coverage (Aggregate)\*

\$3 million

Malpractice must be active on or before the requested start date for the practice.

\*Upload a copy of your malpractice insurance verification. This must include the practitioner's name on the certificate to be valid.

Upload Malpractice Insurance\*

Add File...

✖ Malpractice Example.docx

## Provider Enrollment Application

< **Auth to Bill** You are almost done. See instructions below to complete your applica >

### Auth to Bill

Date of Request (MM/DD/YYYY)

08/04/2023

Name of Clinic, Group, or Professional Association\*

Healthy Hearts

Will bill for and receive charges or fees for my services effective (MM/DD/YYYY)\*

11/13/2023

EIN Number\*\*

01478521

Practitioner First Name

Angelica

Practitioner Last Name

Pickles

Practitioner SSN\*\*

001122334

Practitioner's NPI\*\*

9632587410

Practitioner's Email Address\*

angelica.pickles@abctestng.com

Representative Name\*

Tony Bennett

Representative Title

Office Manager

Representative's Contact Telephone Number

803-586-0002

Representative's Email Address\*

tony.bennett@help.com

Must match the requested start date with the practice on page one of the application.

## Provider Enrollment Application

< You are almost done. See instructions below to complete your application. >

**You are almost done. See instructions below to complete your application.**

To complete your submission, go to the documents section under Form Information. Download your application, print, apply your signature, and re-upload them using the Upload Files button. Please note that your downloadable application will take a few minutes to appear.

Please note that:

1. You can always find your files under the "My Forms" section. Make note of your case number for easy access.
2. If contracts are required, they will be found in the "My Contracts" section with the reference to your case number.
3. If you need assistance, use the communication case comment section in this case. This way both you and your representative will have all the information and questions in one location.

\*- required

Back

Save & Exit

Next

Select Next.

# My Form

## COMMUNICATION

 Case Comments (0) ▼


## FORM FORM INFORMATION

**Application Status:** [Awaiting Signature](#)      **Application Type:** [Individual Application](#)      **Case Number:** 00030455      **Date Received:** [August 4, 2023](#)  
**Contact Name:** [Terrence Archie](#)      **Practitioner Name:** [Angelica Pickles](#)      **Networks Chosen:** [Blue Essentials; Medicare Advantage; State Health Plan; Preferred Blue® \(PPC and FEP\)](#)

**Please wait for at least five minutes for the PDF files to generate.**


You confirm that all required documents have been completed appropriately; all applications, associated forms, and contracting documents have been signed and/or initialed and dated (with current date) as indicated on these documents, and the required information/documentation and signed forms have been uploaded to the case.

**Confirm**


 Files (4)

Upload Files

 Authorization to Bill -- 2023-08-04 12\_58pm.pdf  
Aug 4, 2023 • 142KB • pdf

 Provider Enrollment Application -- 2023-08-04 12\_58pm.pdf  
Aug 4, 2023 • 350KB • pdf

 State License Example.docx  
Aug 4, 2023 • 12KB • docx

 Malpractice Example.docx  
Aug 4, 2023 • 12KB • docx

If some of your files do not generate, Select Upload Files to add any missing documents.



FORM FORM INFORMATION

**Application Status:** [Submitted](#)

**Application Type:** [Individual Application](#)

**Case Number:** [00030455](#)

**Date Received:** [August 4, 2023](#)

**Contact Name:** [Terrence Archie](#)

**Practitioner Name:** [Angelica Pickles](#)

**Networks Chosen:** [Blue Essentials](#); [Medicare Advantage](#); [State Health Plan](#); [Preferred Blue® \(PPC and FEP\)](#)

**Thank you for uploading your documents.**

## CONTRACTS AWAITING SIGNATURE

Form Contract Name	Network List	Form Type	Contract
FCR-12433	Blue Essentials	Individual Application	<a href="#">View</a>
FCR-12434	Medicare Advantage	Individual Application	<a href="#">View</a>
FCR-12435	Preferred Blue® (PPC and FEP)	Individual Application	<a href="#">View</a>
FCR-12436	State Health Plan	Individual Application	<a href="#">View</a>

[View All](#)

## Your Contracts Awaiting Signature

### HELP:

This page contains the contracts that require your signature based on the Network that you have chosen to enroll in.

To download your contracts, click the link under **DOWNLOAD CONTRACT**.

Once you have signed the required contracts, upload them using the **UPLOAD FILES** button below.

If you are unsure what this contract is for, click the link under **CASE** to see which application this contract is associated with.

### Contract Information

Form Contract Name

FCR-12433

Case

[00030455](#)

Form Type

Individual Application

Contact's Email

-----

Status

Awaiting Signature

Chosen Network

Blue Essentials

Download Contract

[https://bcssc12.my.salesforce.com/sfc/p/5f000000H7sW/a/5f000000XhGI/\\_rMjim6.xgkDcpY2QXiaMPvkKTZR5V\\_P.kKhayI8Jbc](https://bcssc12.my.salesforce.com/sfc/p/5f000000H7sW/a/5f000000XhGI/_rMjim6.xgkDcpY2QXiaMPvkKTZR5V_P.kKhayI8Jbc)

Remember to download, sign and upload the contracts to your case.

## Once you've Signed your Contract, Upload it Below

Files (0)

[Upload Files](#)

[Upload Files](#)

Or drop files



# **MAKING CORRECTIONS TO AN APPLICATION**



# MAKING CORRECTIONS TO AN APPLICATION

## Correcting Applications

- All corrections must be made in the portal.
  - Allows the system to track the corrections and applies them to the appropriate fields.
  - The newly generated documented will have the corrections and should be printed, signed, dated and initialed.
- Handwritten corrections will not be accepted and will be returned.

# MAKING CORRECTIONS TO AN APPLICATION

Below is the information we are missing:

Here are your next steps:

1. If you are **ONLY** correcting information in the application:

- **CLICK** the Form tab to make your corrections in the application.
- **CLICK** the **NEXT** button at the bottom of each section.
- **AFTER** clicking the last **NEXT** button, **WAIT** until the new forms generate
- **DOWNLOAD** the updated PDFs to have them signed.

2. If you are **ONLY** uploading files and **DID NOT** correct any information in the application:

- **UPLOAD** your files **FIRST**.
- **CLICK** the **CONFIRM** button below the Documents section.

3. If you are correcting information in the application **AND** uploading files:

- **CORRECT** the information in the form like in Step 1 **FIRST**.
- **UPLOAD** the applicable files after the new PDFs are generated like in Step 2.
- **AFTER** your signed documents have been uploaded, click the **CONFIRM** button below the Documents section.

# MAKING CORRECTIONS TO AN APPLICATION

## COMMUNICATION

 Case Comments (1) 

 [ginelle c](#) 

Public:

Created Date:

8/4/2023, 6:36 PM

Comment:

The TIN for this test case is missing a digit.

[View All](#)

## FORM FORM INFORMATION

**Application Status:** [Awaiting Provider Response](#)

**Application Type:** [Individual Application](#)

**Case Number:** [00030455](#)

**Date Received:** [August 4, 2023](#)

**Contact Name:** [Terrence Archie](#)

**Practitioner Name:** [Angelica Pickles](#)

**Networks Chosen:** [Blue Essentials; Medicare Advantage; State Health Plan; Preferred Blue® \(PPC and FEP\)](#)

# MAKING CORRECTIONS TO AN APPLICATION

## My Form

### COMMUNICATION

Case Comments (1)

ginelle c

Public:

Created Date:

8/4/2023, 6:36 PM

Comment:

The TIN for this test case is missing a digit.

View All

### FORM FORM INFORMATION

## Provider Enrollment Application

< Office Practice Information Electronic Claim Filing Requirement Provider Discl >

INCORRECT

### Group Information

Group EIN/TIN#\*

01478521

CORRECTION

### Group Information

Group EIN/TIN#\*

014785210

You confirm that all corrected/missing documents/information, with the appropriate signatures/initials and dates if required, have been uploaded to the case.

Confirm



# RESOURCES





# RESOURCES

## Available Resources

Visit [www.SouthCarolinaBlues.com](http://www.SouthCarolinaBlues.com) and follow the path:

*Providers>Provider Enrollment>My Provider Enrollment Portal*

[My Provider Enrollment Portal Manual](#)

[Provider Enrollment Presentation](#)

[Provider Enrollment FAQs](#)



**THANK YOU!**

