South Carolina

BlueChoice® HealthPlan South Carolina

Registration Form for Midlevel and Hospital-Based Providers

(Complete this form to join the BlueCross, State Health Plan, Medicare Advantage and BlueChoice® networks.
If you are being credentialed for BlueChoice HealthPlan Medicaid, please complete the SC Uniform Credentialing Application.)

First Name:	Last Name:	Middle Initial:	Title: (DO, MD, CRNA, NP, PA)

SSN:	NPI #:	Medicare #:

Date of Birth:	Male ☐ Female ☐	Language(s) spoken:

Practitioner Type: ☐ Radiologist ☐ Emergency Medicine ☐ Pathologist ☐ Anesthesiologist
☐ Hospitalist ☐ CRNA ☐ Nurse Practitioner ☐ Physician Assistant

SC License/Registration #:	DEA Certificate # *(if applicable):*

Hospital Affiliations *(if applicable): If more than one listed, please indicate primary affiliation.*

Name of Graduate School:	Year Graduated:

Accepting New Patients: ☐ Yes ☐ No	Age Limitations: Min Age_____ Max Age_____	Gender Restrictions: ☐ Male ☐ Female

Board Certification:

Primary Specialty: _____ Certifying Board: _____ Date Certified: _____
Expiration Date: _____

Secondary Specialty: _____ Certifying Board: _____ Date Certified: _____
Expiration Date: _____

Malpractice Insurance Policyholder: ☐ Self ☐ Facility ☐ Other

Service Address Information

Fax the completed application to 803-264-4795.

Primary Service Address	Additional Service Address
Practice Name:	Practice Name:
Physical Address:	Physical Address:
Credentialing Contact's Name:	Credentialing Contact's Name:
Appointment Phone:	Appointment Phone:
Fax:	Fax:
Email **(Required)**:	Email **(Required)**:

Practice Information

Tax ID Number	NPI (Group or Facility, if applicable):	Billing Contact's Name:	
Checks to Be Made Payable to:		Billing Phone #:	Fax #: Email **(Required)**:
Payment Address:			
Mailing Correspondence Address:			

Practitioner's Signature

(Application will not be processed without signature)

Signature:	Date: