PROVIDER ENROLLMENT

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 APPLICATIONS AND FORMS

Applications	Used for…
Individual Enrollment	New practitioners that want to enroll with BlueCross (***not for Behavioral Health***)
Group Practice Enrollment	New groups that want to enroll with BlueCross
Facility Information Request	Medical facilities that want to credential with BlueCross
Virtual Care Services	Practitioners or groups that want to render telemedicine and telehealth services
Health Professional	***In-state, out-of-network*** 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
Satellite Location	***Enrolled groups*** that have ***new locations*** that want to file claims

Forms	Used for…
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
NPI Provider Notification	***Out-of-state and out-of-network*** practitioners or groups 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

INDIVIDUAL ENROLLMENT – ANCILLARY PROVIDERS

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.**

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.

INDIVIDUAL ENROLLMENT – ADVANCED PRACTICE 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.**

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.**

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.

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.**

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.**

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.**

GROUP PRACTICE ENROLLMENT – HOME HEALTH, HOSPICE, ETC.

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.**

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.**

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.

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)

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.

OUT-OF-STATE, OUT-OF-NETWORK

Checklist Items
NPI Notification Form
Copy of W9

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.

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

WHAT HAPPENS WHEN AN APPLICATION IS RECEIVED

- **The provider enrollment team reviews applications to determine if they are clean and completed.**
  - Only clean applications can be sent to the Credentialing Committee for review.
    - Applications that are incomplete or missing items are sent back to the provider and they have ***21 days*** to return the necessary documentation.
    - If the missing items are not received, the application will be canceled on the 28th day.
- **Applications approved by the Credentialing Committee progress through the process and are sent to contracting for review.**
  - Applications that are not approved by the Credentialing Committee are sent to the Disciplinary Committee.
    - The outcome of the review is sent to the provider.
- **Once contracting reviews and executes the contracts, the application is sent to the enrollment team to load the provider into the system.**
  - If contracts are not executed, an explanation is sent to the provider.
- **After the provider is loaded into the system, a welcome email is sent to the provider and includes the network and affiliation dates.**

THINGS TO KEEP IN MIND

- **The Credentialing Committee reviews enrollment applications to ensure all required credentialing criteria is met.**
- **Network effective dates are determined by the Credentialing Committee's approval date per the following entity requirements:**
  - Utilization Review Accreditation Commission (URAC)
  - National Committee for Quality Assurance (NCQA)
  - South Carolina Department of Health and Human Services (SCHDDS), when applicable
- **Network effective dates cannot be backdated.**
- **Affiliation dates can be backdated.**
  - Affiliation dates are used to process commercial claims.
  - Can be backdated up to Jan. 1st of the previous year.

PROVIDER ENROLLMENT REMINDERS

PROVIDER ENROLLMENT REMINDERS

Unsigned applications or contracts

- All applications, contracts and required documents must be signed, initialed and dated.

Invalid dates

- Malpractice dates must be valid and active on or before the requested start date.
- State licenses must be active with current dates.
- Signature dates on applications and contracts must be current.

Incomplete submissions

- Licenses, certificates (CLIA, when applicable) and malpractice verification must be included with the application.

Incomplete documentation

- All documents must be filled out in its entirety (i.e., Authorization to Bill for Services).

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.

RECREDENTIALING PROCESS

- **Recredentialing for established providers occurs every three years.**
  - If you need to know the upcoming recredentialing dates for a provider, email Recred.App@bcbssc.com.
    - Include the provider's name and NPI.
- **The credentialing team reaches out when the provider's recredentialing dates is approaching.**
  - First, the team calls to see if the provider is actively working at the location we have on file. If they are, the recredentialing application is sent by email or fax.
    - If a response is not received after the first outreach, a second attempt is made in 14 days.
    - If a response is not received after the second outreach, a third attempt is made in seven days.
    - If a response is not received after the third and final outreach, the process to terminate the provider is initiated.
- **If the recredentialing date is missed, the provider is termed, and new enrollment is required.**

NON-CREDENTIALED PROVIDERS

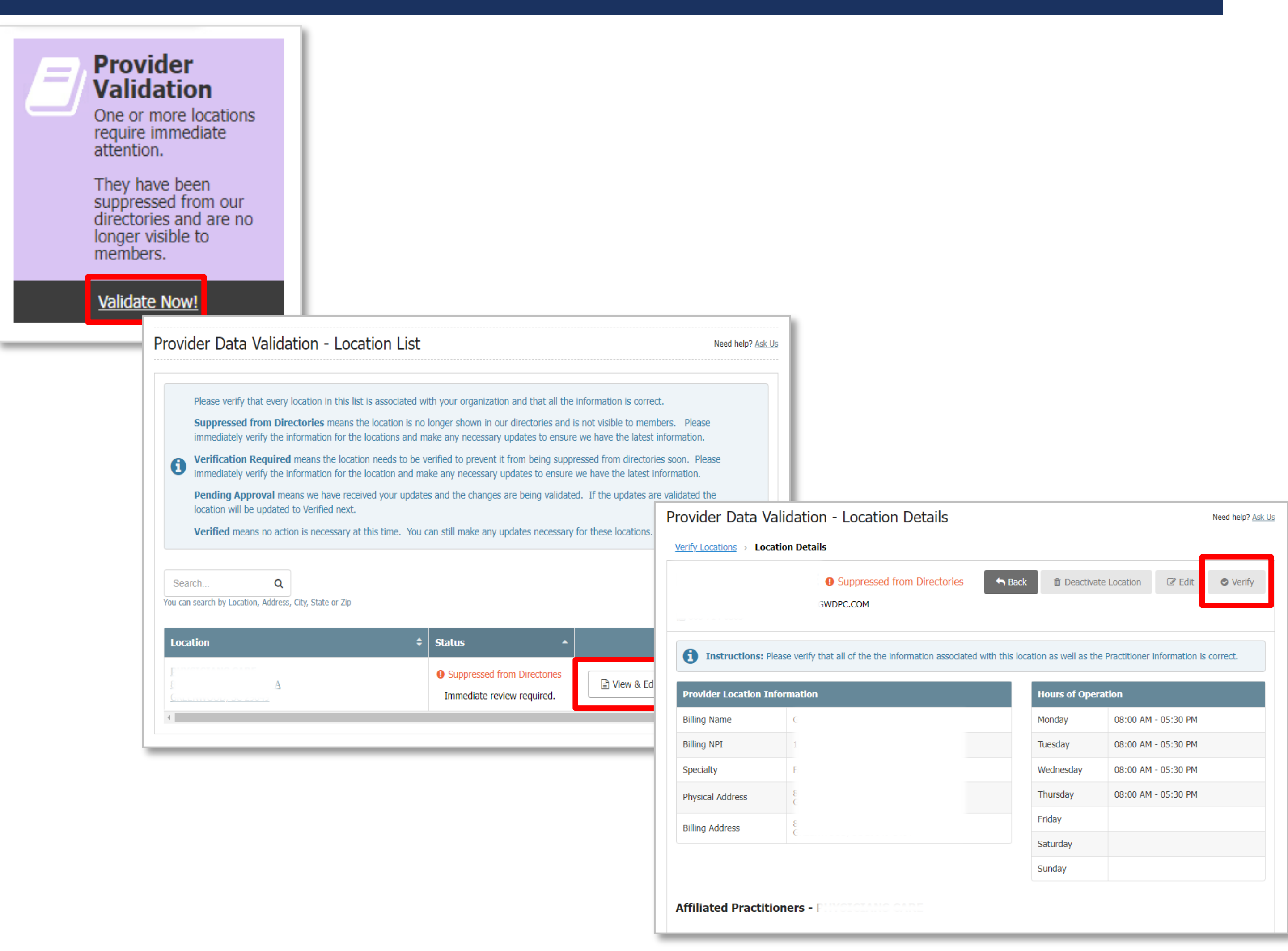
Note: This list may not be all inclusive.
****Can join the Healthy Blue network.***

PROVIDER DIRECTORY VALIDATION

- Providers have been required to verify their demographic data at least ***every 90 days*** since Jan. 1, 2022.
  - This implementation was part of the No Surprises Act.
- Validation allows us to maintain accurate directories.
- Verification can be completed in M.D. Checkup (accessible through My Insurance Manager℠).
  - You can also respond to the email received from Provider.Directory@bcbssc.com.

LOCATION SUPPRESSIONS DUE TO MISSING VALIDATION

- 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℠
  - 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



MAKING DEMOGRAPHIC UPDATES

My Provider Enrollment Portal

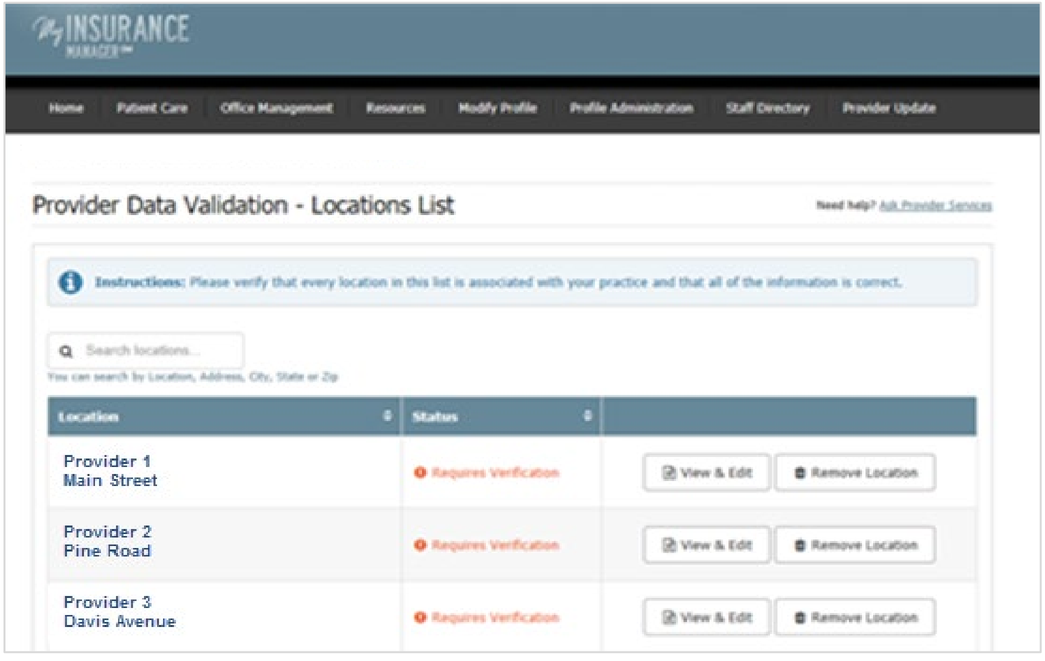
- Doing Business As Name Change
- Change of Address
- Satellite Location
- Add or Terminate Practitioner Affiliation

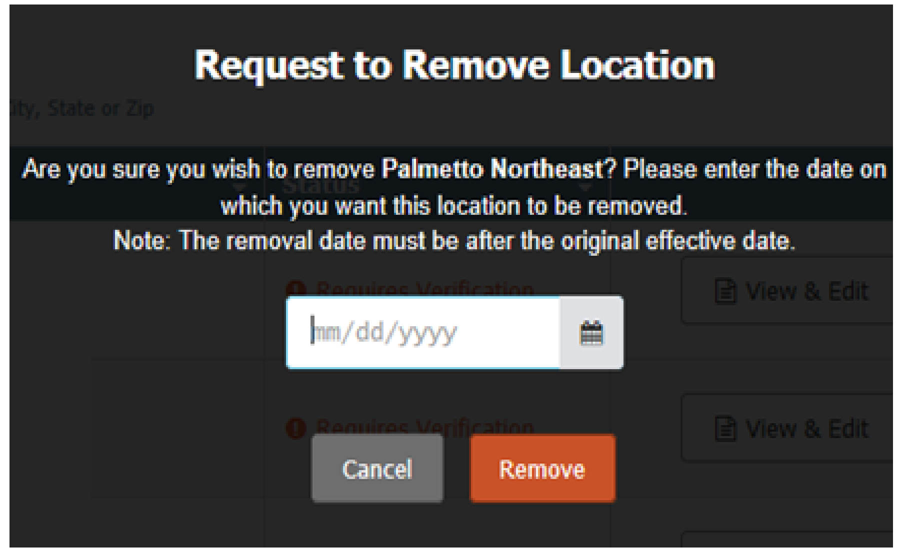
M.D. Checkup

- Terminate (close) Location
- Add or Terminate Practitioner Affiliation

*Note: You can only add a practitioner in M.D. Checkup if they are **enrolled and associated** with the tax identification number (TIN).*

TERMINATING LOCATIONS IN M.D. CHECKUP





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

ADDING PRACTITIONER AFFILIATIONS IN M.D. CHECKUP

- The practitioner must be ***enrolled and associated*** with the Tax ID.
  - If you are trying to add a practitioner to a different Tax ID, you must complete and submit the ***Add Practitioner Form*** in My Provider Enrollment Portal.
- Example:
  - TIN A – 123456789
    - Location 1: 123 Omega St., Columbia, SC 29203
    - Location 2: 456 Alpha Rd., Hopkins, SC 29061
  - TIN B – 987654321

Dr. Jane Doe is enrolled and associated with TIN A. She works at location 1 but is scheduled to see patients at location 2. She will be submitting claims for location 2 and needs to be added. Because Dr. Doe is already associated with TIN A, she can be added to location 2 through M.D. Checkup.

Dr. Jane Doe is enrolled but not associated with TIN B. She is scheduled to see patients at this new location. Because Dr. Doe is not associated with TIN B, the Add Practitioner Form must be completed and submitted through My Provider Enrollment Portal.

MY PROVIDER ENROLLMENT PORTAL OVERVIEW

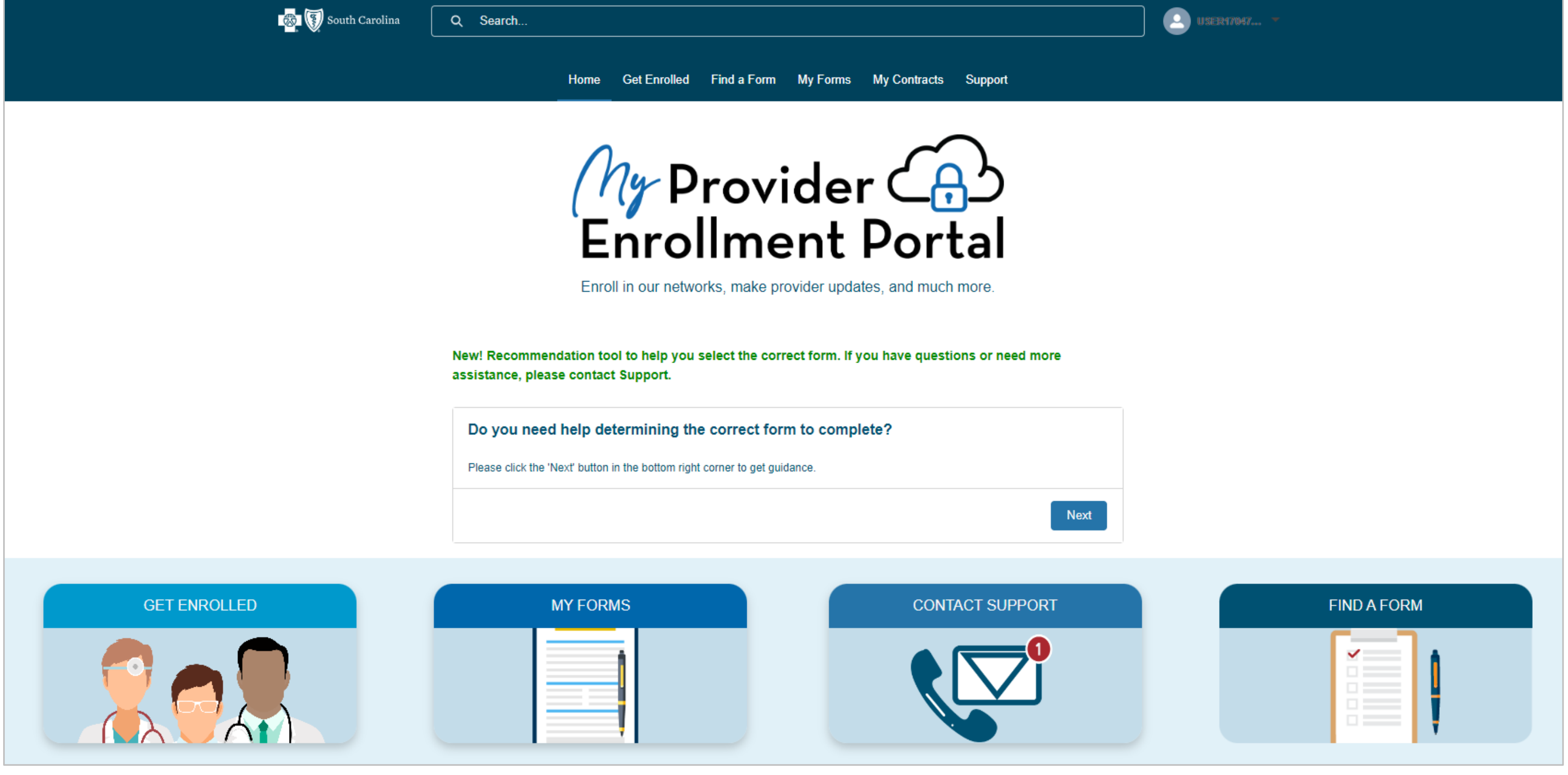
GETTING STARTED WITH THE PORTAL

Sign Up for Access to the Portal

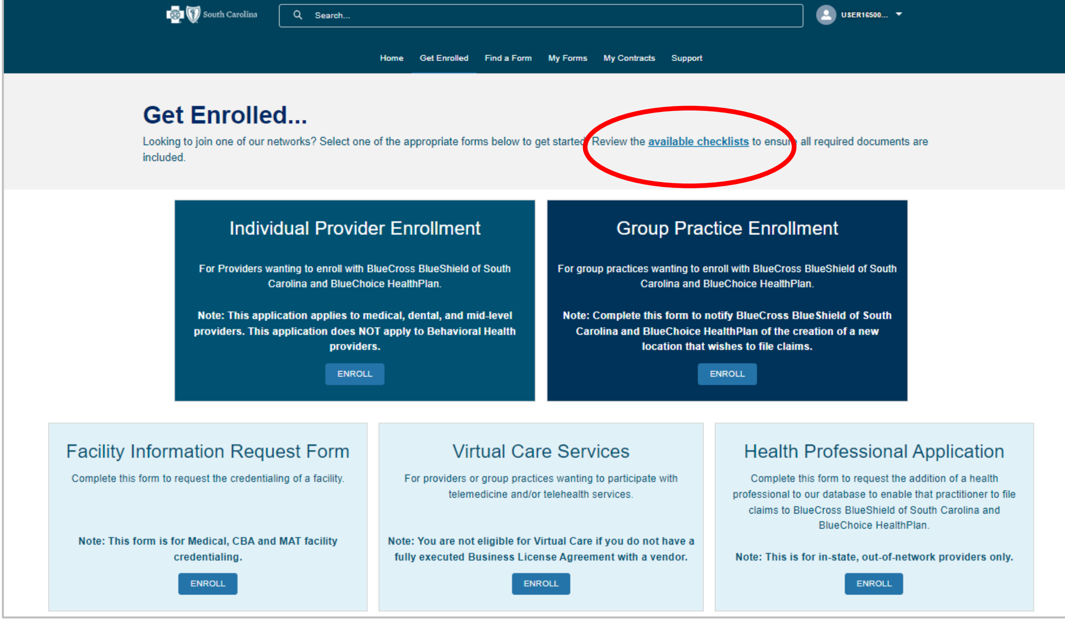
Visit www.SouthCarolinaBlues.com

Providers>Provider Enrollment>My Provider Enrollment Portal

MY PROVIDER ENROLLMENT PORTAL – HOME PAGE



MY PROVIDER ENROLLMENT PORTAL – GET ENROLLED PAGE



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***	✓ Footnote 3	✓	✓				
Medicaid ID Number****	✓	✓	✓		✓	✓	✓

*Only if applicable.

**Only if applying for BlueChoice® HealthPlan

***Required for MDs, DOs and DPMs (at minimum, residency.)

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

[1]Only for NPs, PAs, and Hospitalists.

[2]Only needed for NPs and PAs. needed for hospitalists that are MDs, DOs or DPMs.

[3]Only needed for hospitalists that are MDs, DOs or DPMs.

[4]Medical contract, dental contract, or both.

[5]Dental contract only.

[6]Malpractice coverage for pharmacists is $1M/$1M.

After selecting Enroll for Individual.

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.

[1]CMS letter must include Medicare PTAN.

[2]For oral surgeons applying for BlueChoice and Healthy Blue. All other contracts depend on the individual physician's credentialing status.

After selecting Enroll for Group Practice.

MY PROVIDER ENROLLMENT PORTAL – FIND A FORM PAGE

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

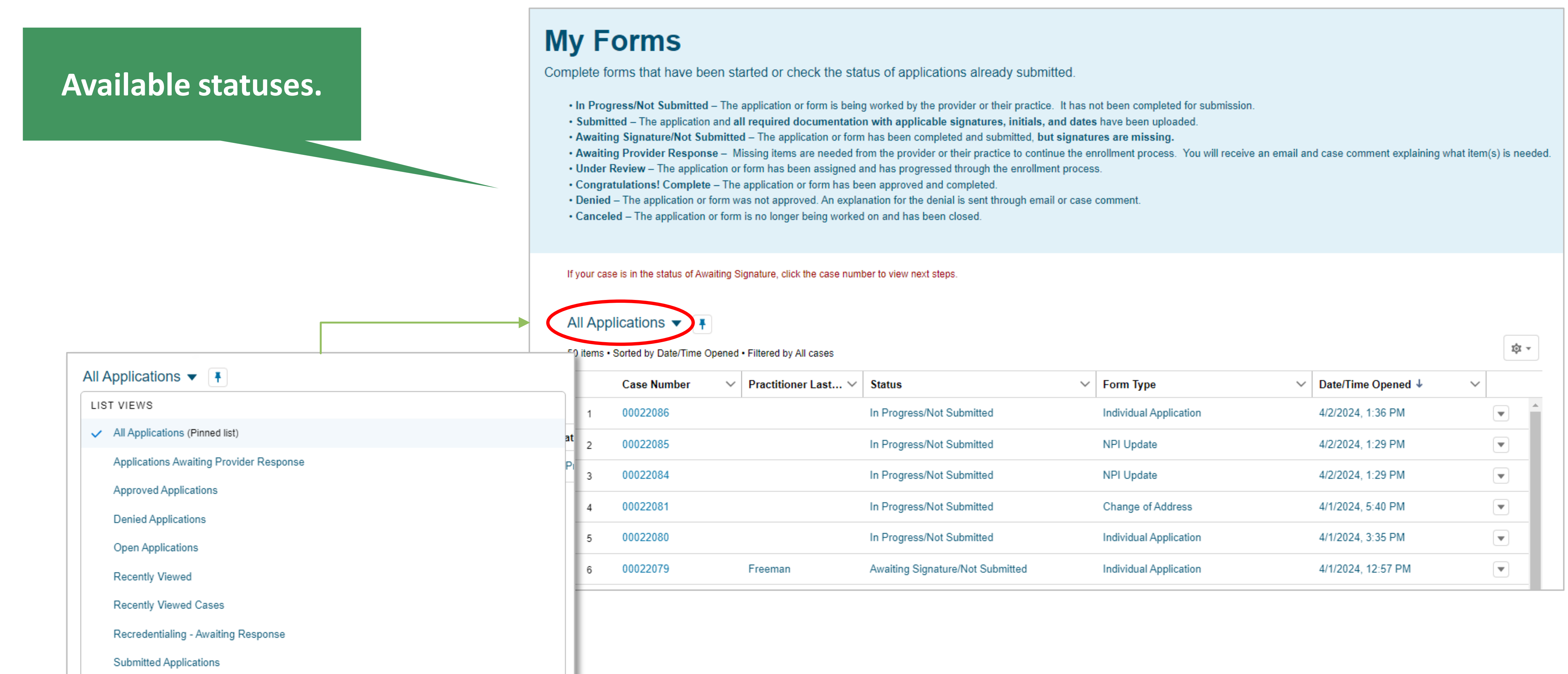
Please complete this form to request the addition or termination of a health professional's association with your clinic, group, professional association, or institution for BlueCross BlueShield of South Carolina for Preferred Blue®, BlueChoice HealthPlan, Healthy BlueSM, FEP and/or State Health Plan.

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

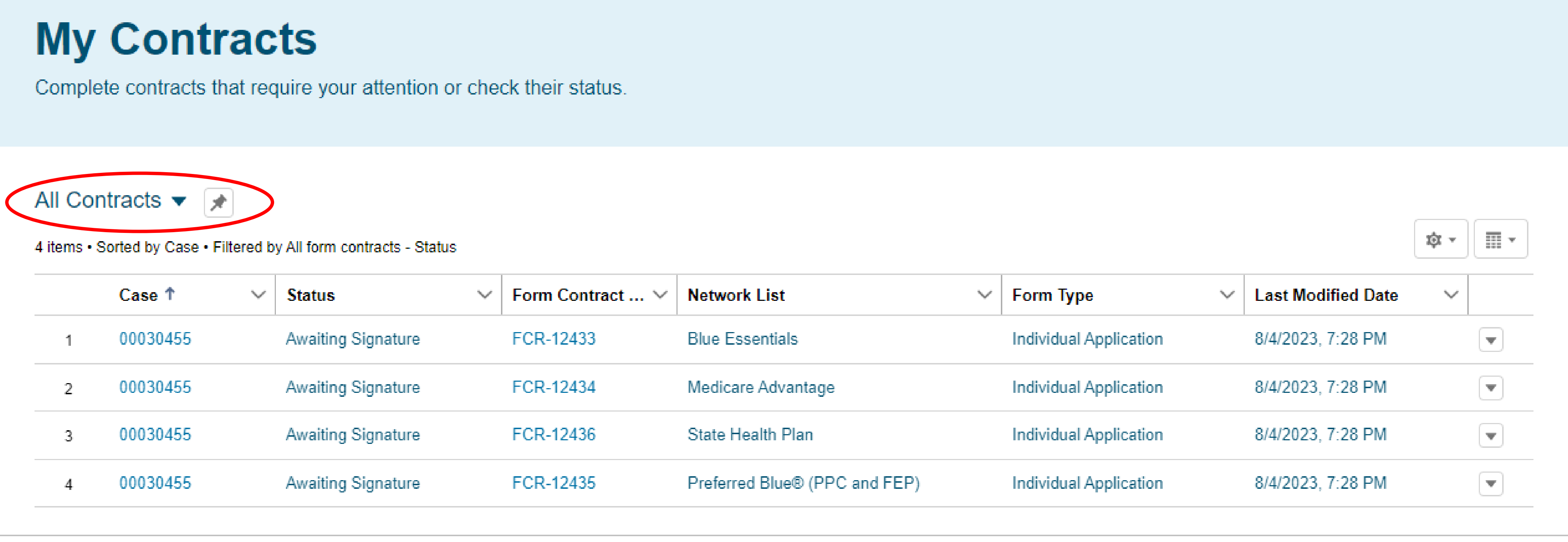
COMPLETE FORM

MY PROVIDER ENROLLMENT PORTAL – MY FORMS PAGE

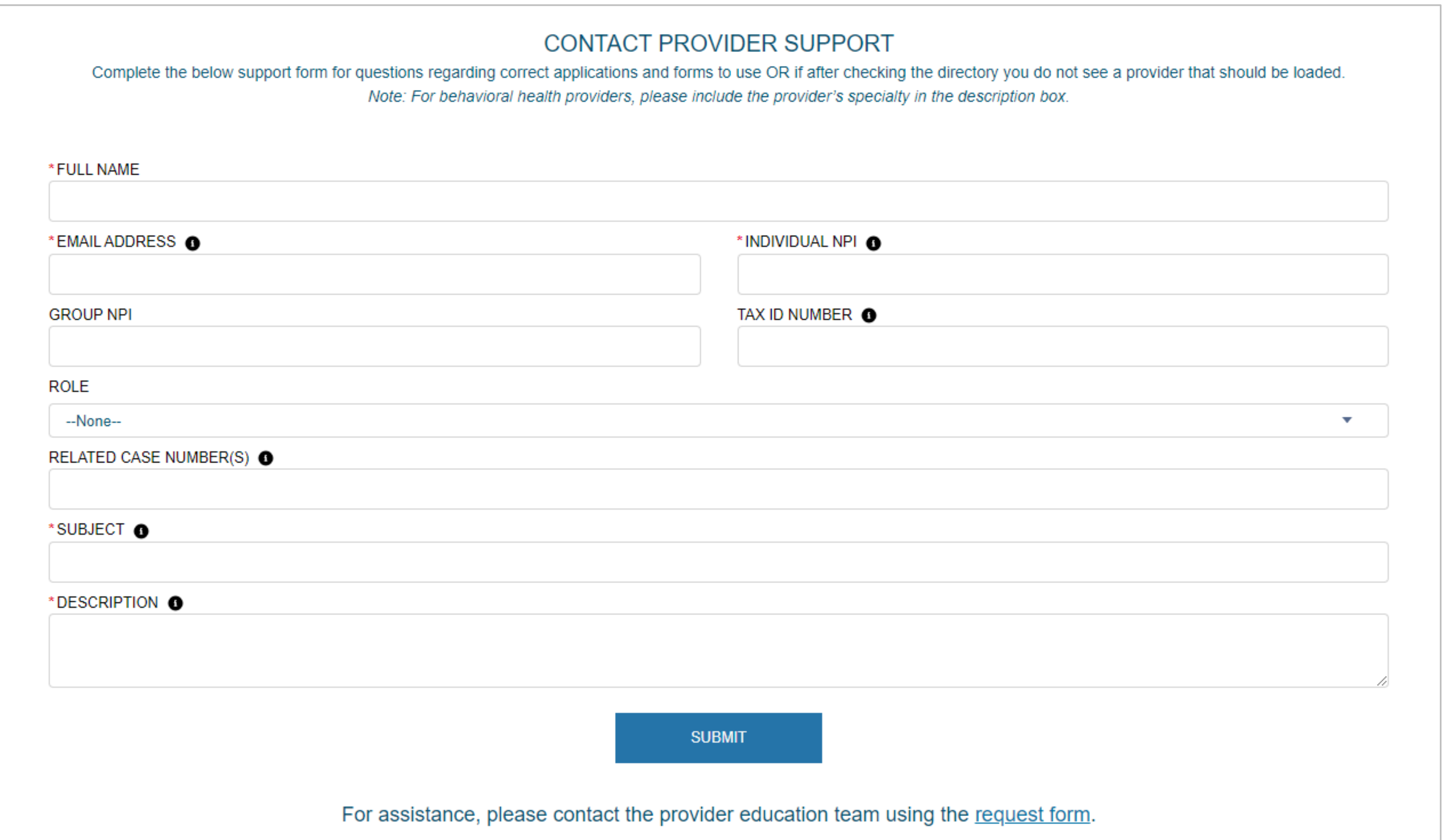
Available statuses.



MY PROVIDER ENROLLMENT PORTAL – MY CONTRACTS PAGE



MY PROVIDER ENROLLMENT PORTAL – CONTACT SUPPORT PAGE


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

*EMAIL ADDRESS

*INDIVIDUAL NPI

GROUP NPI

TAX ID NUMBER

ROLE

--None--

RELATED CASE NUMBER(S)

*SUBJECT

*DESCRIPTION

SUBMIT

For assistance, please contact the provider education team using the request form.

MY PROVIDER ENROLLMENT PORTAL – IMPORTANT ITEMS

Case Numbers

- Generated with each application, form and support case.

Contracts

- Provided during the application review process and must be included with the application.

Case Comments

- Used for case-specific questions on an application or form.

Statuses

- Used to let you know where the application is in the enrollment process.

Note: You should not manually change your statuses.

MY PROVIDER ENROLLMENT PORTAL – STATUSES

Status	Description
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 – STATUSES (CONTINUED)

Status	Description
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.

COMPLETING A CLEAN APPLICATION

STEPS IN SUBMITTING A CLEAN APPLICATION

1. Complete the enrollment application inside the portal.
2. Download, print and sign (includes signatures, initials and dates) the application and other applicable documents.
   - Scan and upload the signed documents, licenses, etc. to the case.
     - Documents are listed under ***Form Information***.
3. Download, print and sign (includes signatures and dates) all applicable contracts.
   - Scan and upload the signed contracts to the case.
     - Contracts are listed on the home page of the portal, or you can go to ***My Contracts***.

Note: Medical contractual pages must be signed in ink. All behavioral health documents can be signed in ink or electronically.

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℠
- BlueChoice HealthPlan
- Healthy Blue℠
- 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*

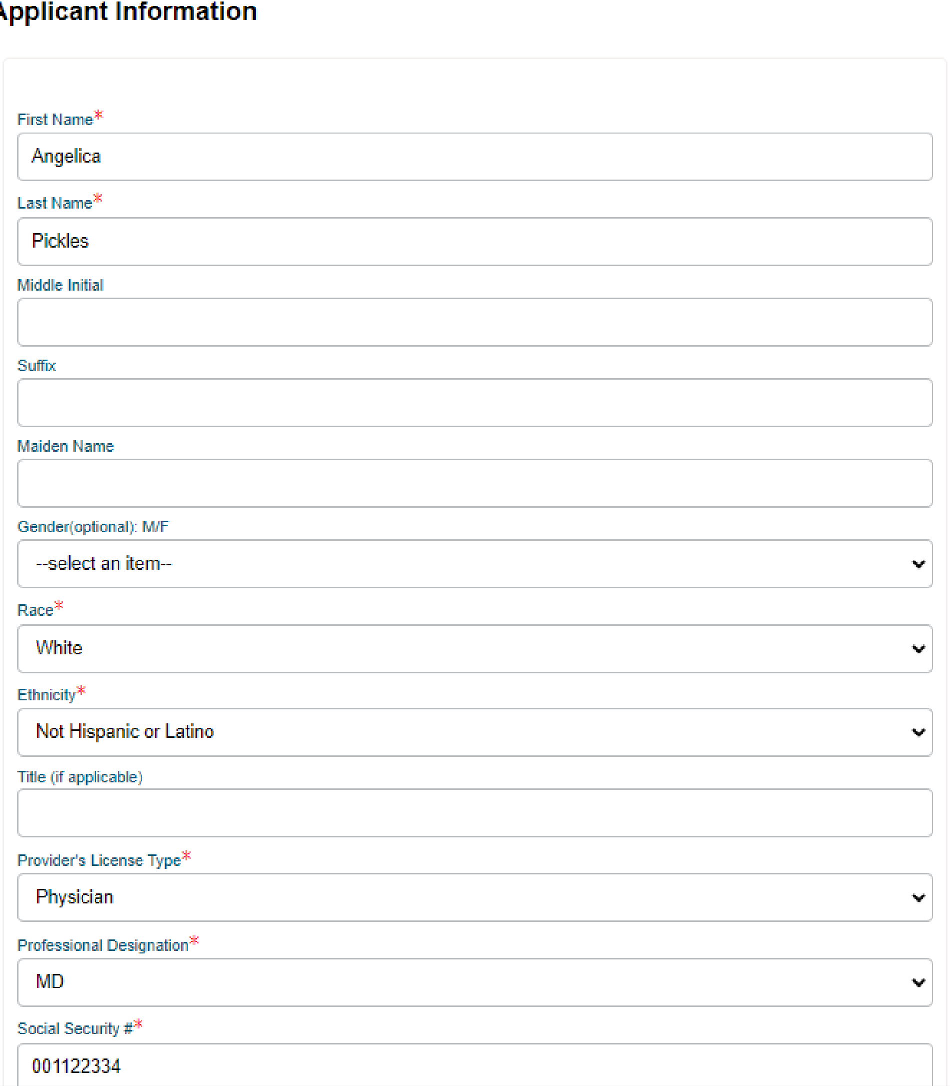
--select an item--

Credentialing Contact Email*

Credentialing Contact Phone*

Preferred Method of Contact*

--select an item--



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

Must match Authorization to Bill.

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

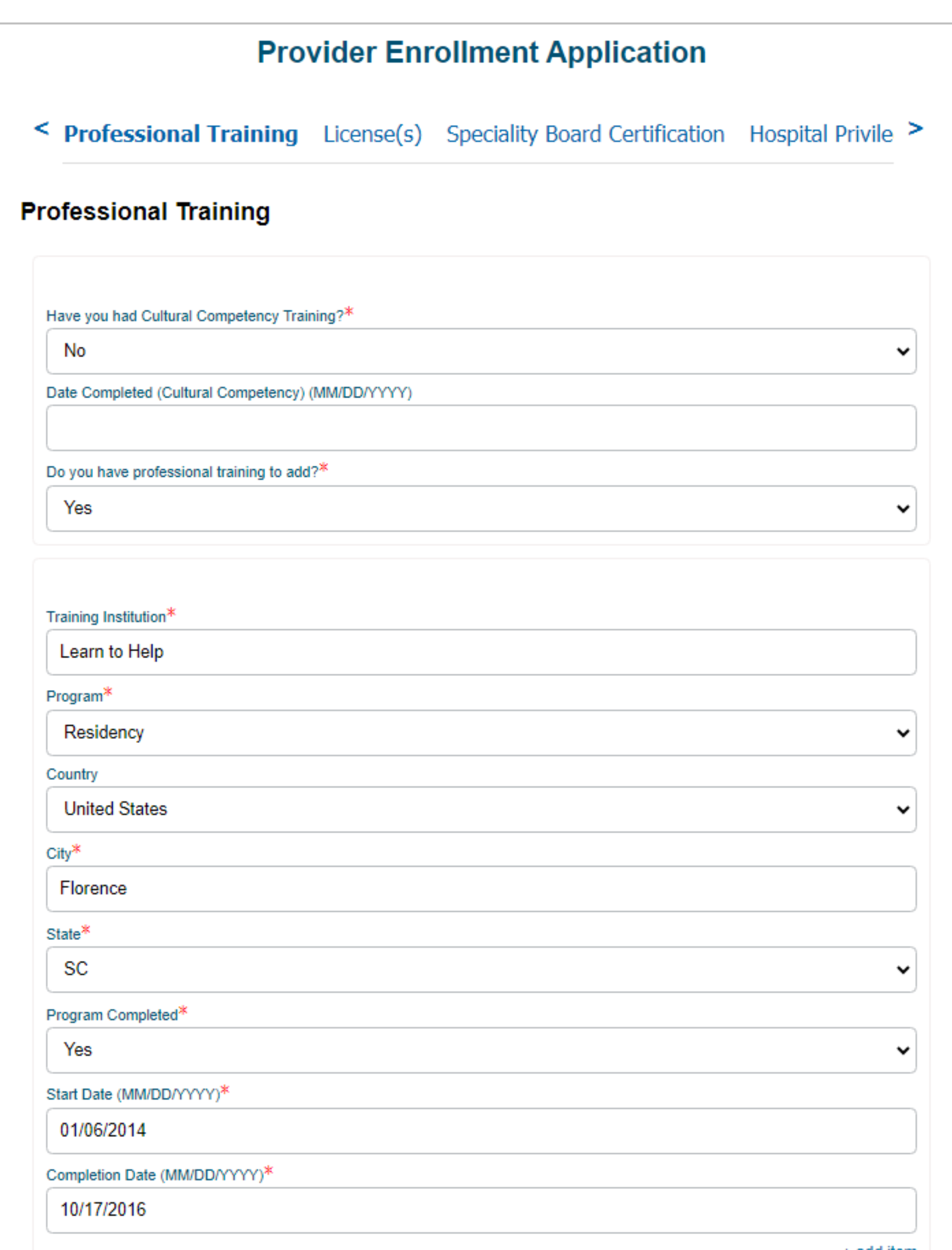
Provider Type*

Specialist

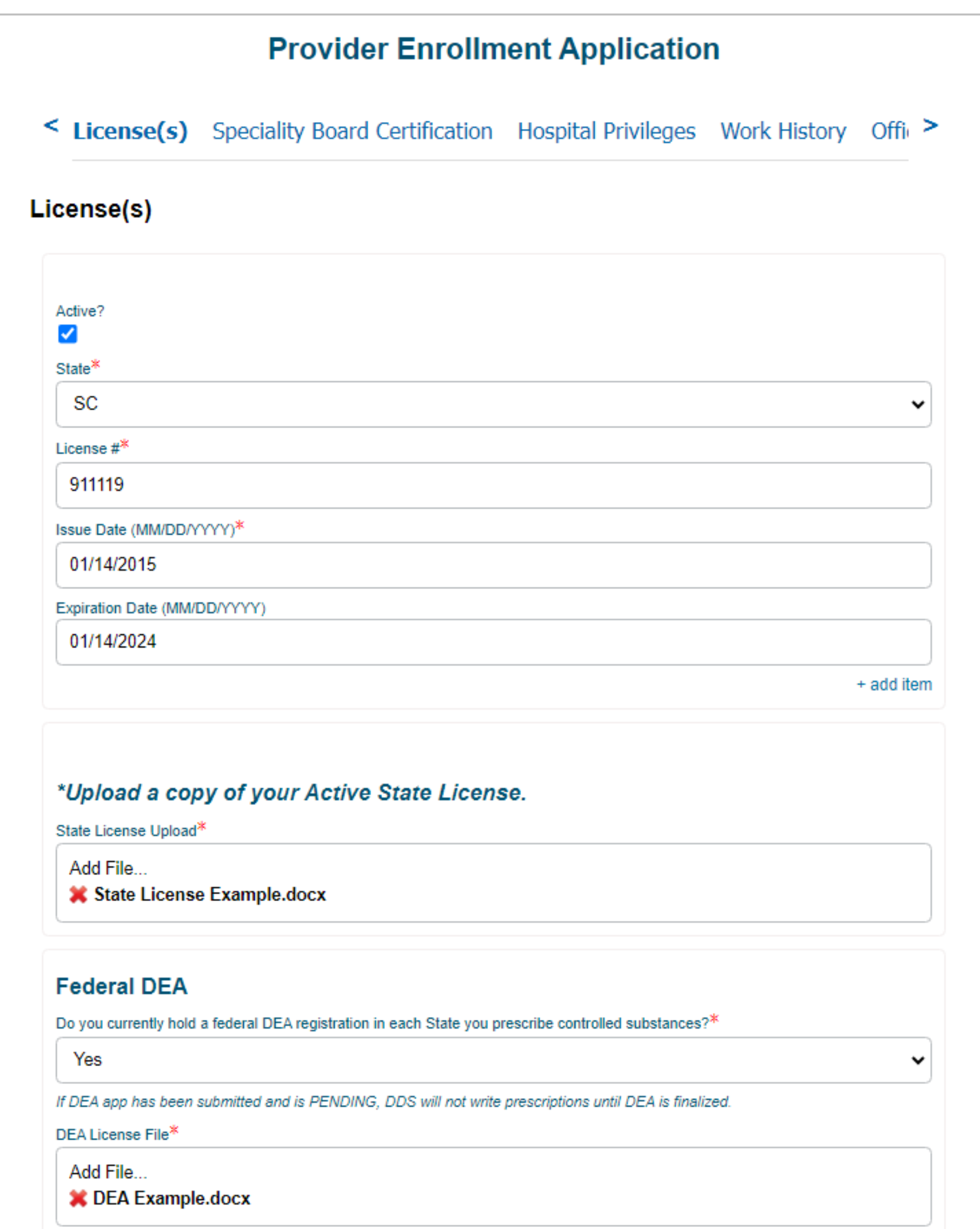
Save & Exit | Next

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

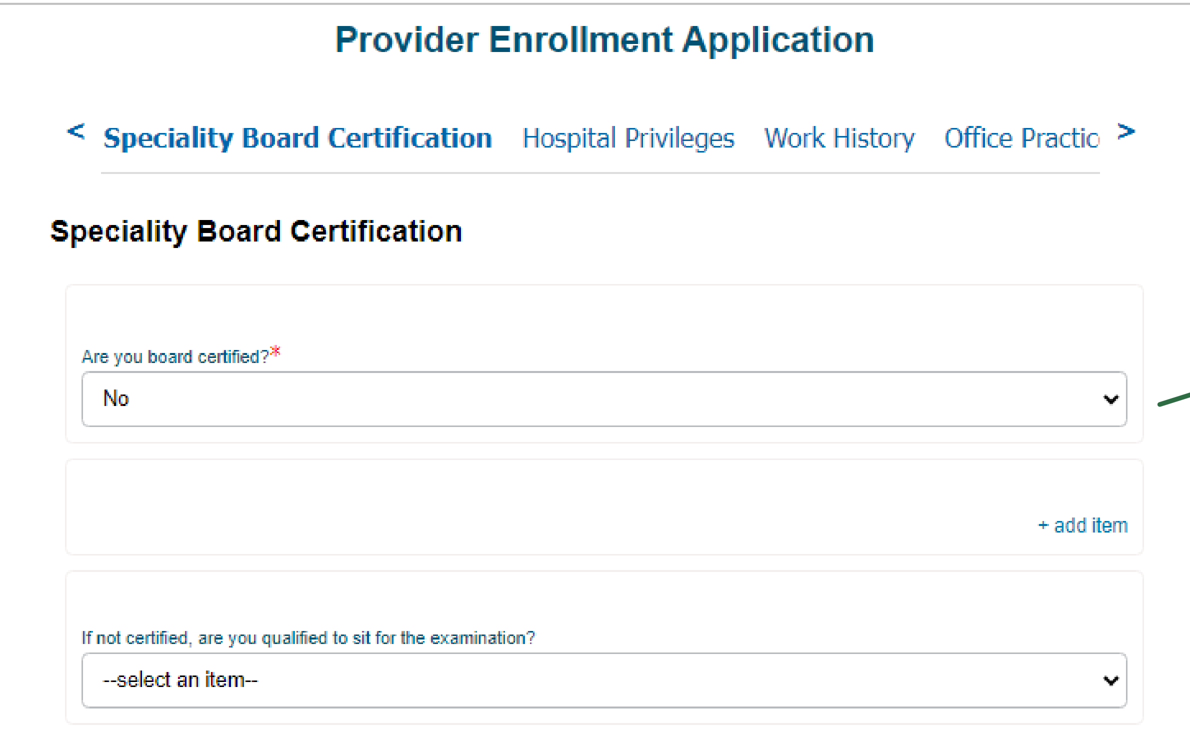
*- required
Back
Save & Exit
Next



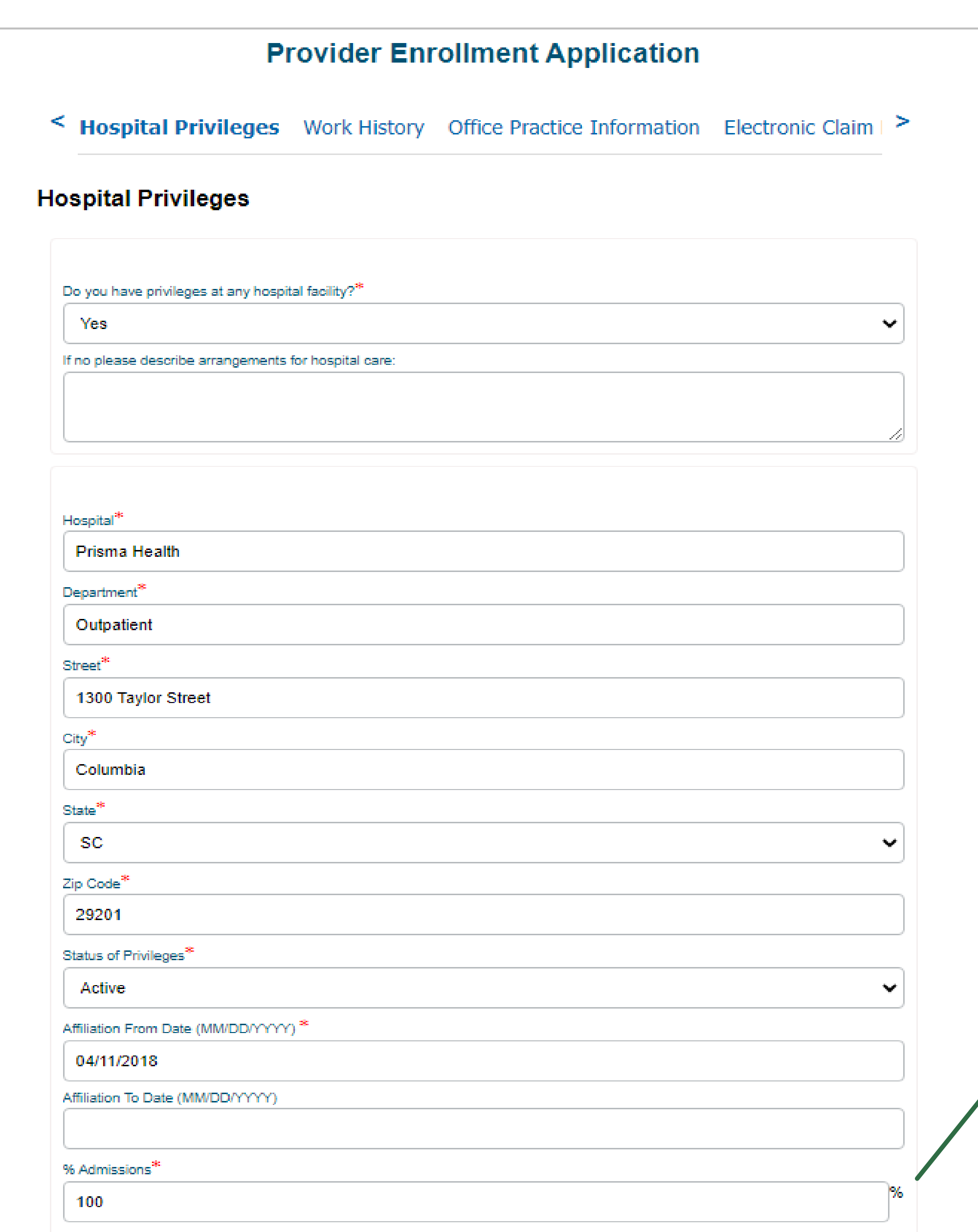
DOs, DPMs and MDs must have a minimum of residency training for credentialing.



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



If you select Yes, additional details are required.



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

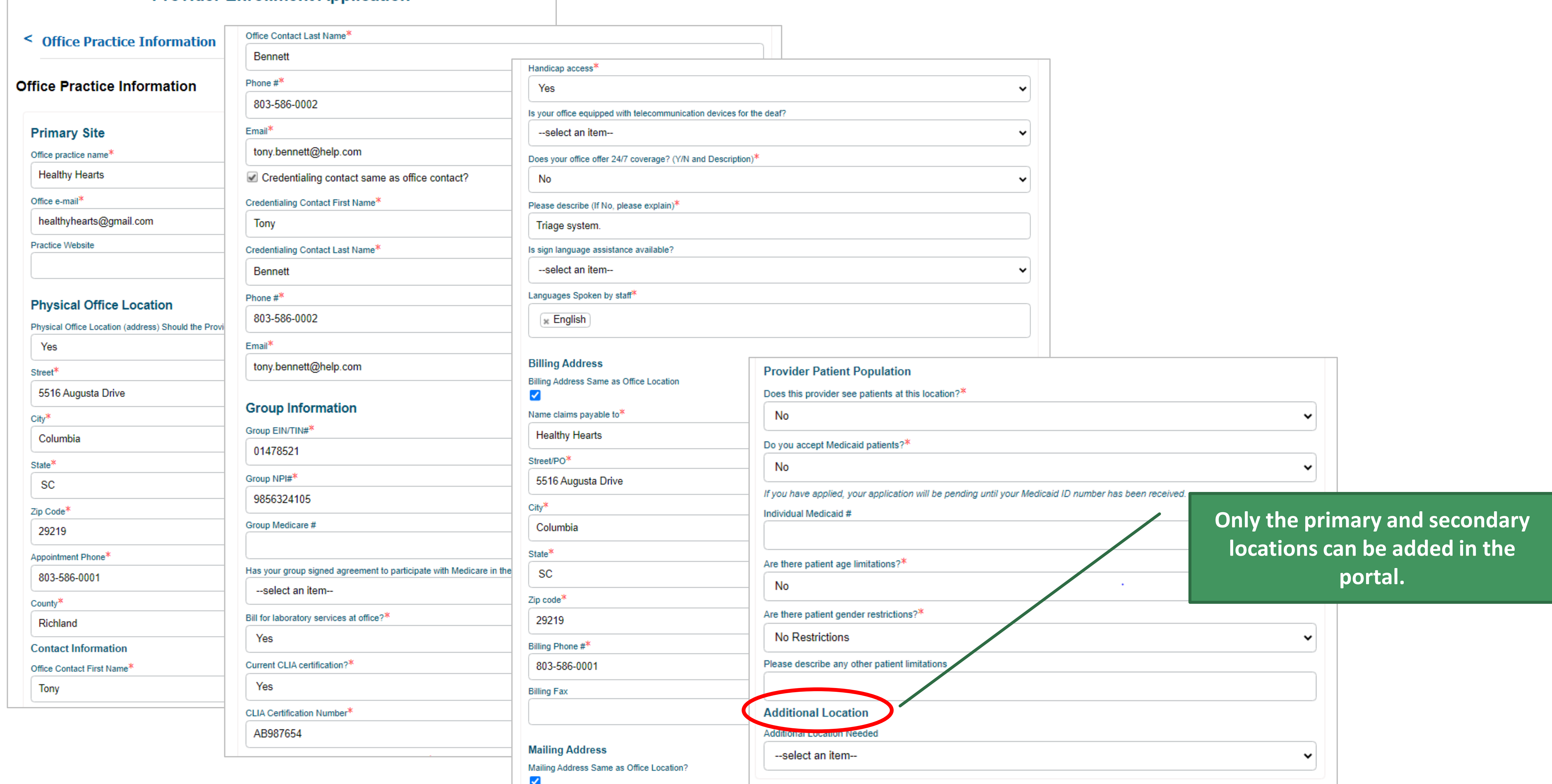
From Date (MM/DD/YYYY)*

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
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 Provi
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
--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--
Only the primary and secondary locations can be added in the portal.

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?*

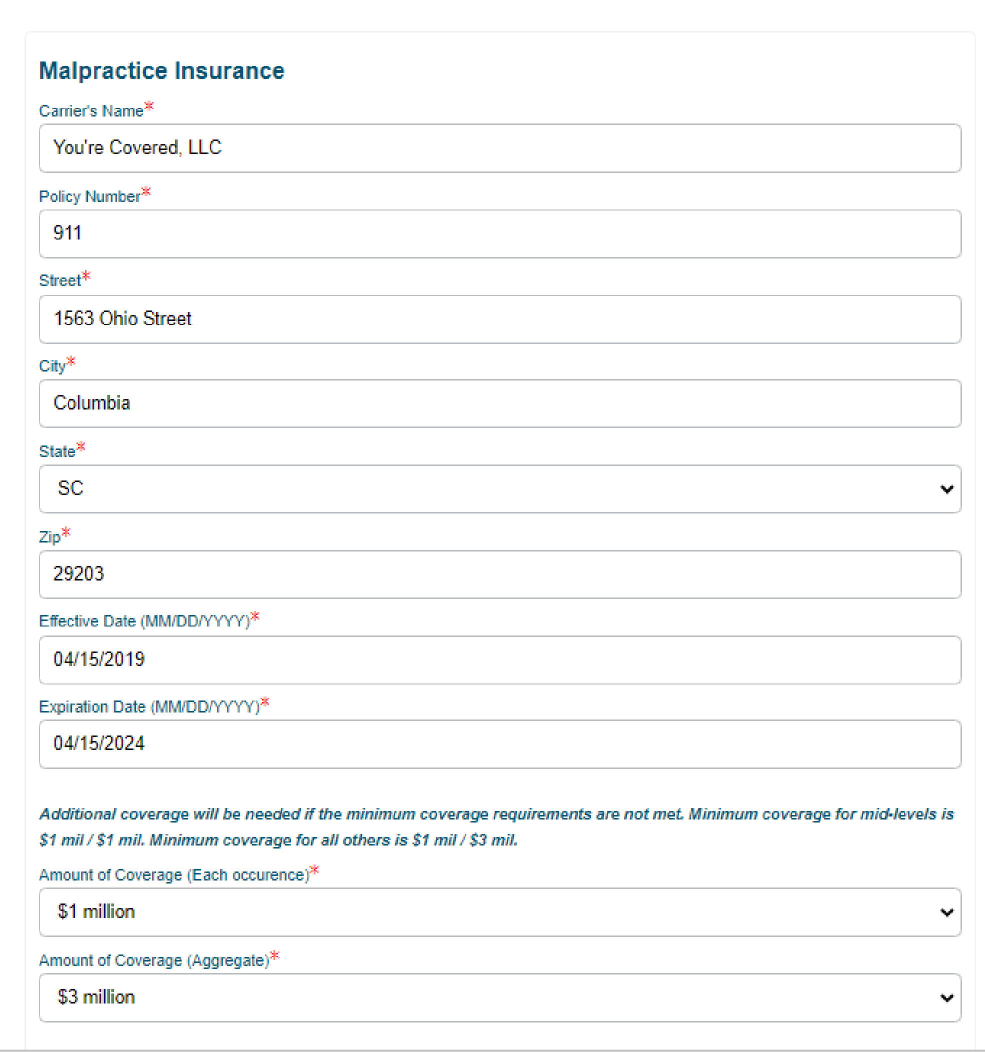
No

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

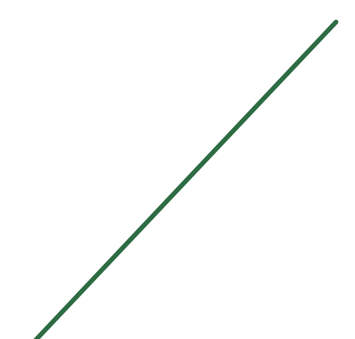
Effective Date (MM/DD/YYYY)*
04/15/2019

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 occurence)*
$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@abctesting.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.

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

2. If contracts are required, t reference to your case numl

3. If you need assistance, us will have all the information a

Medical Documents

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-s into the MyPep Tool. To submit sign

1. Select "My Contracts" fro
2. Sort on "All Contracts"
3. Locate your case number
4. This will take you to a pag
5. Print and sign the docum
6. To upload the signed doc

Behavioral Health Documents

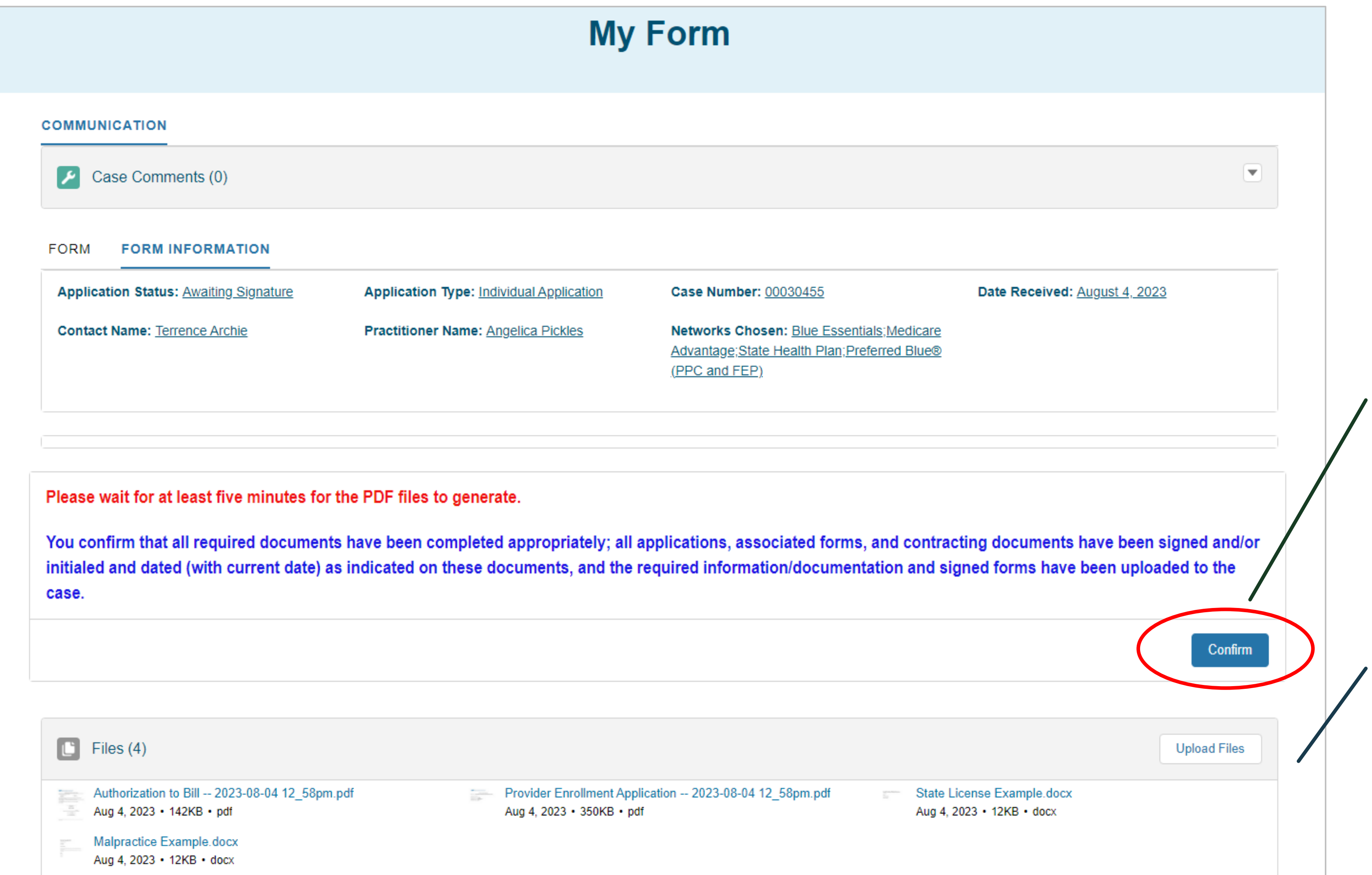
Thank you

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.

No Signature



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

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	View
FCR-12434	Medicare Advantage	Individual Application	View
FCR-12435	Preferred Blue® (PPC and FEP)	Individual Application	View
FCR-12436	State Health Plan	Individual Application	View

View All

Your Contracts Awaiting Signature

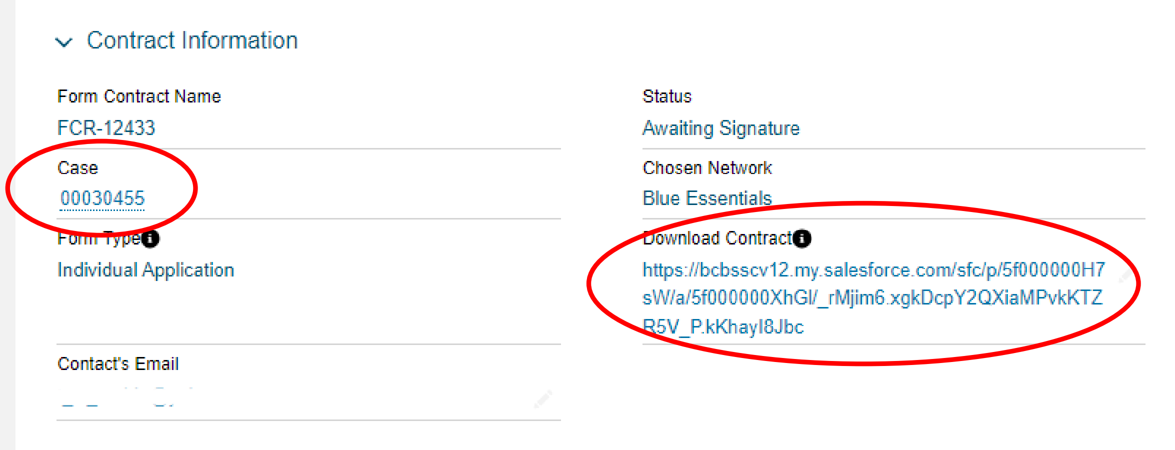
HELP:

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

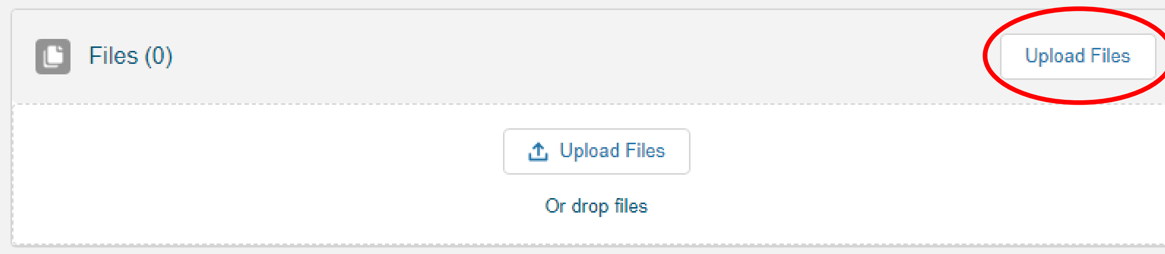
To download your contracts, click the link under **DOWNLOAD CONTRACT.**

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.



Once you've Signed your Contract, Upload it Below



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

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.

STEPS FOR MAKING CORRECTIONS

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.

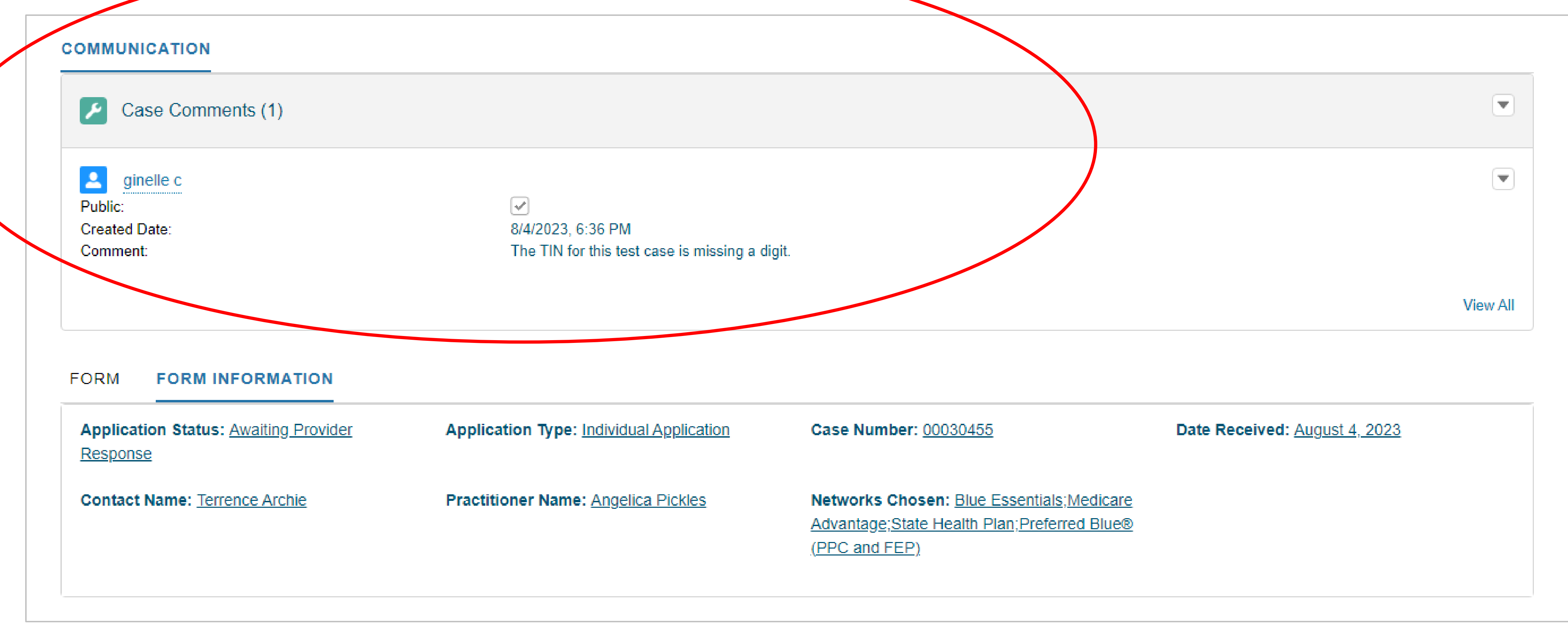
2. If you are **ONLY** uploading files and **DID NOT** correct any information in the application:

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

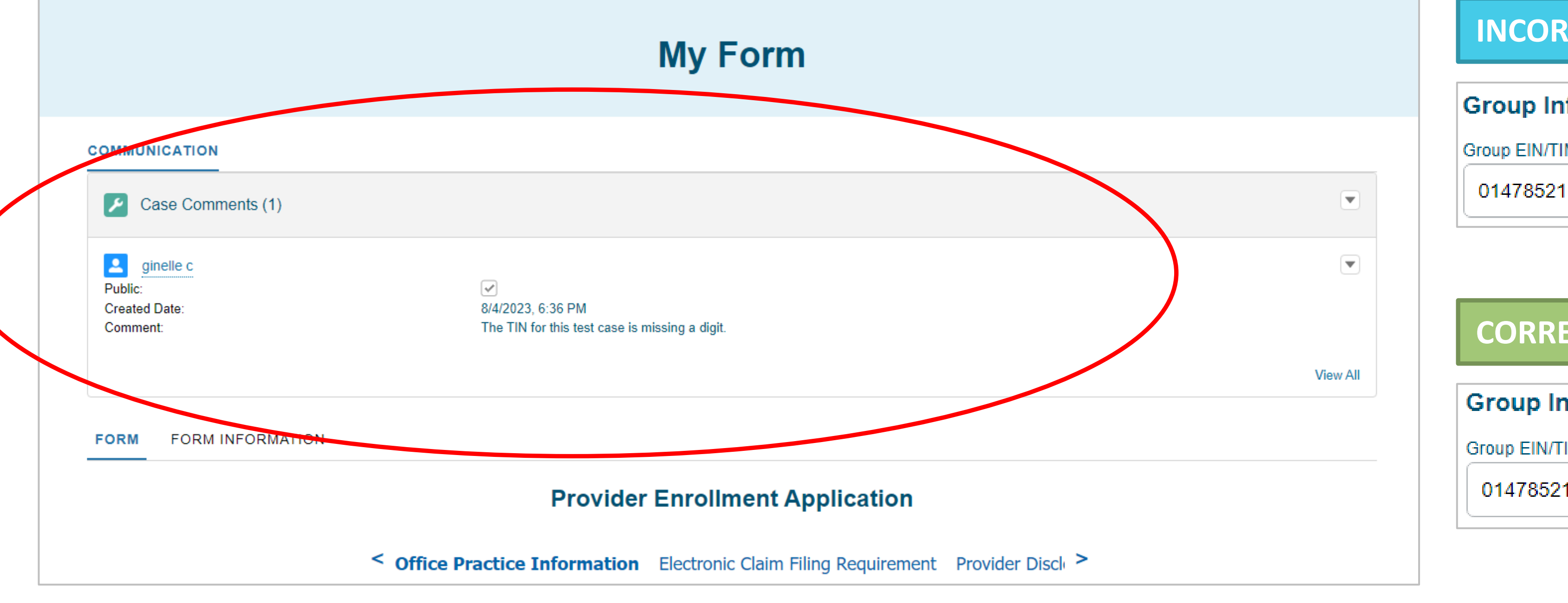
3. If you are correcting information in the application **AND** uploading files:

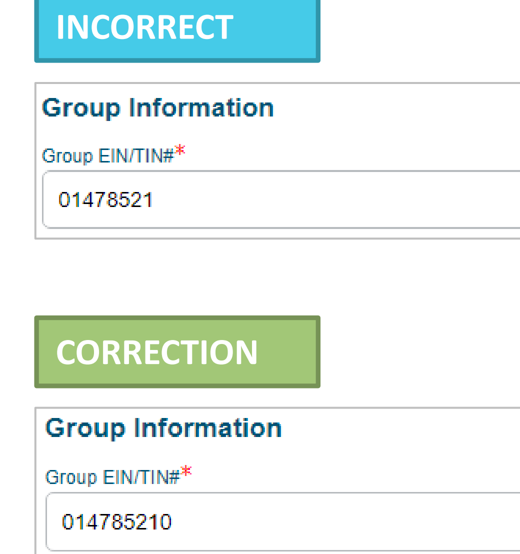
- **CORRECT** the information in the form like in Step 1 **FIRST.**
- **UPLOAD** the applicable files after the new PDFs are generated like in Step 2.
- **AFTER** your signed documents have been uploaded, click the **CONFIRM** button below the Documents section.

EXAMPLE OF A CORRECTION



EXAMPLE OF A CORRECTION (CONTINUED)





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

Confirm

EXAMPLE OF A CORRECTION (CONTINUED)

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.

RESOURCES

AVAILABLE RESOURCES

Visit 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!