BlueCross BlueShield of South Carolina and
BlueChoice® HealthPlan of South Carolina

Independent licensees of the Blue Cross Blue Shield Association.

Provider Enrollment

Frequently Asked Questions

1. **How does a practice change its legal business name (not their "doing business as" name)?**
   To change the legal business name of the practice, the request can be sent via email to Provider.Requested.Info@bcbssc.com. The practice would need to include an updated IRS document showing the new name (Letter 147C, CP 575 E, Tax Coupon 8109-C).
2. **How does a physician change their name if they get married?**
   If a physician gets married and needs to change their name, they should reach out to their provider education consultant and advise they require an update. The provider should include a copy of their marriage license.
3. **Can a physician become part of any network?**
   No. Physicians can only join networks where their group is currently contracted. For instance, a physician may request to join the State Health Plan, Medicare Advantage and Healthy Blue℠. However, if their group only has a contract with Preferred Blue®, that is the only network the physician can join.
4. **Does a physician need to be affiliated with all locations under a facility or practice?**
   No. If the physician is affiliated to the main location of the facility or practice, their claims will process for all associated locations. Physicians are only affiliated to facilities or practices where they are actively and regularly seeing patients.
5. **What is needed to update the change of ownership for a practice?**
   If the tax identification number (TIN) or National Provider Identifier (NPI) has changed, new enrollment paperwork is needed. The practice would need to complete the Group Application.

   This is also true if the owners change, but the TIN and NPI remain the same. The notification can be sent via email to Provider.Requested.Info@bcbssc.com.
6. **Can provider affiliations be completed through M.D. Checkup?**
   Provider affiliations can only be completed through M.D. Checkup if the physician is already enrolled and associated with the base TIN of the practice.

   If you are trying to affiliate a physician to a location under a different TIN, you would need to complete the Request to Add orTerminate Practitioner form.

   Example:

   - TIN A – 123456789
     - Location 1
     - Location 2

- TIN B – 987654321

Dr. Tommy is enrolled and associated with TIN A and works at location 1. He will begin seeing patients at location 2. Because he is already associated with the base TIN, you can complete the new affiliation through M.D. Checkup.

Dr. Tommy is enrolled, but not associated with TIN B. He will begin seeing patients at TIN B. Because he is not associated with TIN B, you would need to complete the Request to Add or Terminate Practitioner form.

7. **Which enrollment applications and forms are used at BlueCross BlueShield of South Carolina?**
   The enrollment applications and forms used at BlueCross include:

Application or form	Used for…
Individual Enrollment	New practitioners that want to enroll with BlueCross (not 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
DBA Name Change	Changing the doing business as (DBA) name of a practice
Change of Address	Updating the physical, pay to, correspondence and billing agency address
Satellite Location	Enrolled groups that have new locations that want to file claims
NPI Provider Notification	Registering an NPI with BlueCross
Add or Terminate Practitioner	Adding or terminating a practitioner's affiliation with a clinic, group or institution

8. **Are electronic signatures accepted?**
   Use these tables to determine which documents can be signed electronically.

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 (DBA)	**Electronic or wet**
Change of Address (CoA)	**Electronic or wet**
Add or Terminate Practitioner	**Electronic or wet**
Authorization to Bill	**Electronic or wet**
Electronic Funds Transfer (EFT)	**Wet**
Appendix D (BlueChoice HealthPlan)	**Wet**
Hold Harmless (BlueChoice® HealthPlan)	**Wet**
ALL Contracts	**Wet**

Behavioral Health Networks

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**

9. **Can a 'DO' provider specialty type join the Healthy Blue network?**
   No. Providers with the specialty of 'DO' (other) cannot join the Healthy Blue network as a true specialty type is needed. This specialty is used for us to verify our federally qualified health centers (FQHC) and rural health clinic (RHC) locations. They are not actual locations that offices can request to be loaded. Each 'DO' location must have a corresponding multi-specialty location with the same address on file.
10. **How does the recredentialing process work?**
    Recredentialing occurs every three years. Our credentialing team reaches out when the provider's recredentialing date is approaching.

    First, the credentialing team calls to see if the provider is actively working at the location on file. If so, the application is sent via email or fax. If a response is not received after the first attempt, a second

attempt is made in 14 days. If a response is not 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 provider misses their recredentialing date, they will be termed, and new enrollment will be required.

11. **How long does the enrollment process take?**
    Currently, it can take up to 120 days for a clean application (meaning all required documentation along with applicable signatures, initials and dates has been received) to process. If there are any missing items, outreach is completed, which could extend the period as the review process cannot move forward without the requested information.
12. **How long do providers have to provide missing items?**
    When applications are missing items, outreach is made every seven days with a 21-day max. If the missing items are not received within 21 days, the case will be canceled due to incomplete submission. At this point, a new application will need to be submitted.
13. **How can I check the status of a submitted application?**
    If the application was submitted through My Provider Enrollment Portal, you can verify the status under My Forms.
14. **How can a provider update their TIN?**
    To update the TIN, the provider would need to complete a new individual or group application.
15. **How can a provider update their NPI?**
    To update the NPI, the provider would need to complete a new individual or group application.
16. **Are providers automatically enrolled in telehealth?**
    No. Providers would need to complete a separate virtual care application to be considered for telehealth services.
17. **What is the difference between the effective date and the affiliation date?**
    The effective date is the date that the provider is approved by the Credentialing Committee and this date cannot be changed.

    The affiliation date is the date in which a provider can render services with an established group. This date can be backdated 45 days from the day we receive all required documentation. Any date past 45 days will require a claim to be submitted with the requested backdate as the date of service to show the provider was rendering services with the group at the time of approval.

    For requested dates greater than 45 days, if the application is pending, email a copy of the claim to Provider.Requested.Info@bcbssc.com. If the application is completed, fax a copy of the claim to 803-264-4795.
18. **How often do providers have to validate their demographic information?**
    With the implementation of the No Surprises Act which went into effect on Jan. 1, 2022, providers are required to validate their demographic data at least every 90 days. If more than 90 days has passed since the providers' last validation, we are required to suppress them from our directories.
19. **Which provider types are not credentialed by BlueCross?**
    BlueCross will not credential the following provider types. Note: this list may not be all inclusive.

Acupuncturists	Associate Counselors	Christian Science Practitioners	Diabetes Education	Dieticians	Education Specialists
Homeopaths	Lay Midwives	Massage Therapists	Naturopaths	Occupations Therapy Assistants	Physical Therapy Assistants
Psychology Assistants	Recreational Therapists	School Psychologists	Speech Therapy Assistants	Sports Trainers	Technicians

20. What happens if a location is closed through M.D. Checkup?

If a location is closed in M.D. Checkup, it will be closed in our claims system. Only complete this action when you truly want to terminate the location. Once a location is terminated, it cannot be undone, and providers would have to complete a new Satellite Location application.