



Physician Recognition Program Payment Request Form

To apply for payment, please complete all of the requested information below for each individual physician and return to BlueCross BlueShield of South Carolina and/or BlueChoice HealthPlan. Please make sure you enclose your letter(s) of recognition /certification and W-9.

1. Physician Information:

Name _____
Social Security # _____
Billing Number _____
Group Practice Name _____

Address to send Payment: _____
Street _____
City, State, ZIP Code _____

2. Please check with which plans you contract: BlueCross Preferred Blue[®] BlueChoice HealthPlan

3. Please check which programs for which you have achieved Recognition/Certification. (Be sure to enclose your letter(s) of recognition or certification.)

ADA / NCQA Diabetes Physician Recognition Program
 AHA / ASA / NCQA Heart/Stroke Recognition Program
 American Society of Hypertension (ASH) Specialists Program

4. Please sign and date this application below indicating that you have met and agree to the BlueCross BlueShield of South Carolina/BlueChoice HealthPlan Physician Recognition Payment Terms and Conditions. By signing you are also indicating that you have not previously received payment from the company for any of the above programs.

Signature Date

Please check here if you do not wish to be recognized for successful completion of any of the above programs in BlueCross or BlueChoice HealthPlan press releases or via other means (e.g. Plan directory, advertisement).

5. Complete the W-9 form.

6. Send the W-9, Request Form and Letter/Certificate of Achievement to:

BlueCross:
Kelli Ritter, AF-316
BlueCross BlueShield of South Carolina
I-20 @ Alpine Rd
Columbia, SC 29219

BlueChoice HealthPlan:
Karen Levan
P.O Box 6170
Columbia, SC 29260

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