

## APPLICATION FOR SATELLITE LOCATION

Please complete this form to notify BlueCross BlueShield of South Carolina of the creation of a new location that wishes to file claims for Preferred Blue® (PPC), State Health Plan and/or FEP. If submitting an NPI, please include your confirmation letter from NPPEs. Fax the completed form and appropriate documentation to 803-264-4795.

If you have questions about this form, you may send those questions to Provider.Cert@bcbsc.com. If the practitioner is changing addresses, he or she must complete the *Change of Address* form. If a practitioner is leaving a clinic/group, he or she must complete a *Termination for Clinic/Group Billing*.

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

(Please type or print)

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

Name of Business: \_\_\_\_\_

Federal Tax ID (EIN): \_\_\_\_\_

Effective Date: \_\_\_\_\_

Date Clinic/Group Open For Business: \_\_\_\_\_

Previous Tax ID, if applicable: \_\_\_\_\_

National Provider Identifier (NPI): \_\_\_\_\_

Previous NPI, if applicable: \_\_\_\_\_

Practice/Institution Location Address:

Payment Address:

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

County: \_\_\_\_\_

County: \_\_\_\_\_

Practice Appointment Phone #: \_\_\_\_\_

Practice Fax #: \_\_\_\_\_

Type of Business:

\_\_\_\_\_ Professional Assoc/Clinic/Partnership  
 \_\_\_\_\_ General Acute Care Hospital  
 \_\_\_\_\_ Rehabilitation Institution  
 \_\_\_\_\_ Psychiatric Institution  
 \_\_\_\_\_ Alcohol/Substance Abuse Institution  
 \_\_\_\_\_ Other (Specify) \_\_\_\_\_

\_\_\_\_\_ Skilled Nursing Facility  
 \_\_\_\_\_ Home Health Agency  
 \_\_\_\_\_ Hospice  
 \_\_\_\_\_ Pharmacy Only  
 \_\_\_\_\_ Pharmacy with DME Sales

\_\_\_\_\_ Independent Clinical Lab  
 \_\_\_\_\_ Physiological Lab  
 \_\_\_\_\_ Portable X-Ray Supplier  
 \_\_\_\_\_ Outpatient Diagnostic Ctr.  
 \_\_\_\_\_ Othotics/Prosthetics

**All professional associations, corporations, partnerships & clinics must complete this section:**

Medicare Group Number: \_\_\_\_\_

List each practitioner who will be providing services at this location:

Name	Social Security #	NPI	Primary Specialty
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**All hospitals, institutions and other facilities must complete this section:**

License #: \_\_\_\_\_ (Attach copy of license)

Are you JCAHO accredited? \_\_\_\_\_ No \_\_\_\_\_ Yes (Attach copy of accreditation)

Are you state certified? \_\_\_\_\_ No \_\_\_\_\_ Yes (Attach copy of certification)

Are you cardiac rehabilitation certified? \_\_\_\_\_ No \_\_\_\_\_ Yes (Attach copy of certification)

Medicare Certification #: \_\_\_\_\_ Certification Date: \_\_\_\_\_ (Attach copy of Medicare certification)

Indicate the number of beds, excluding exempt units: \_\_\_\_\_

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Contact Person: \_\_\_\_\_ Contact Person's Phone # \_\_\_\_\_

E-mail Address (required for notification when we complete changes): \_\_\_\_\_