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

South Carolina Uniform Managed Care Practitioner Credentials Update Form

I. Demographic Information

A. Full Name: ____ Date of Birth: __________________________________

Gender (optional): ________________ Race (optional): ________________ Ethnicity (optional): _______________

B. Practice Name: ____

Primary Care Physician? ☐ Yes ☐ No Specialty: ____

C. Social Security Number: __________________________________ NPI: __________________________________

Tax ID: __________________________________ Group NPI: __________________________________

Medicaid ID: __________________________________ CLIA Number: __________________________________

D. Address: ____

Office Phone Number (for appointments): ______________________ Office Fax Number: ______________________

Office Credentialing Contact Person: _________________________ Contact Phone Number: ______________________

Email Address (required): ____

E. Primary Admitting Facility: ____

Are your hospital privileges active and in good standing? ☐ Yes ☐ No

If you do not admit, please list your admitting plan or the physician that covers your hospitalized patients:

____

Do you speak any other languages? ☐ Yes ☐ No

If yes, please specify: ____

Language(s) spoken by staff? ___________________, ___________________, ___________________

Are you accepting new patients? ☐ Yes ☐ No

Do you currently accept Medicaid? ☐ Yes ☐ No

Are there gender limitations? ☐ Male Only ☐ Female Only ☐ Both

Are there age limitations? ☐ Yes ☐ No

If yes, please specify: ____

****Enclose a copy of your current malpractice coverage.**

Carrier Name: __________________________________ Effective Dates: ______________ to ______________

Amount: __________________________________

F. Office Email Address (required): ____

G. Practice Website (if applicable): ____

II. Certification Education Update

A. Are you currently board certified? ☐ Yes ☐ No Certified by American Board of: _________________________

Specialty: __________________________ Date Certified: ______________ Expiration Date: ______________

Secondary Certification: ___________________ Date Certified: ______________ Expiration Date: ______________

B. Medical School/University: _________________________________ Month/Year of Graduation: _________________

C. Professional License Number Where Currently in Practice: ____

III. Please answer the following questions. (This section must be completed by the practitioner.)

Managed Care Organizations must have updated liability information and written explanations to begin the recredentialing process. If you answer “yes” to any of the questions below, please enclose a detailed explanation.

Question	Yes	No
1. Do you have any pending misdemeanor or felony charges?	☐Yes	☐No
2. In the past three years have you been convicted of a felony?	☐Yes	☐No
3. In the past three years has your license to practice medicine in any jurisdiction been voluntarily or involuntarily denied, restricted, suspended, challenged, revoked, conditioned or otherwise limited?	☐Yes	☐No
4. In the past three 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 accommodations, to perform the essential functions of a practitioner in your areas of practice, or unable to perform those essential functions without a direct threat to the health and safety of others?	☐Yes	☐No
5. Considering the essential functions of a practitioner in your area of practice, in the past three 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?	☐Yes	☐No
6. In the past three years have you been publicly reprimanded or disciplined by a professional licensing agency or board?	☐Yes	☐No
7. In the past three years has your DEA certification or state-controlled drug permit been restricted, suspended, revoked, voluntarily relinquished, or otherwise limited?	☐Yes	☐No
8. In the past three years have any of your privileges or memberships at any hospital or institution been denied, suspended, reduced, revoked, not renewed, or otherwise limited?	☐Yes	☐No
9. In the past three years has your participation in Medicare, Medicaid, or any other government program been limited or curtailed, or have you voluntarily excluded yourself from any of these programs?	☐Yes	☐No
10. In the past three years has your participation in an Insurance Company network been limited or terminated?	☐Yes	☐No
11. In the past three years and up to the present, have you had a history of chemical dependency or substance abuse that might affect your ability to perform competently and safely the essential functions of a practitioner in your area of practice?	☐Yes	☐No
12. In the past three 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?	☐Yes	☐No
13. In the past three years has any malpractice carrier made an out-of-court settlement or paid a judgment of a medical malpractice claim on your behalf, or are any medical malpractice suits pending against you?	☐Yes	☐No
14. In the past three years has your professional liability insurer placed conditions or restrictions on your coverage or ability to get coverage?	☐Yes	☐No

Signature: ____ Date: ______________________________

Printed Name: ____

Must be signed in ink.

Each submission requires an original signature and current date. Rubber stamped and electronic signatures are not acceptable.

Practitioners have the right to review information obtained to evaluate their credentialing and recredentialing applications.

IV. Authorization

I certify that all information contained in this credentials update form and all its attachments are accurate, complete, and true. I understand that:

A. Any misrepresentation, misstatement, or omission of a relevant fact in connection with this application may result in denial of my application or termination of my participation in the Managed Care Organization.

B. It is my responsibility to promptly advise the Managed Care Organization in writing within 30 days of any changes or additions to the information contained in this application.

C. All the information contained in this application or attachments is subject to the Managed Care Organization's investigation and review.

Notice: The National Practitioner Date Bank may be queried. If you are not recredentialed for reasons relating to professional conduct or professional competence, which reasons include misrepresenting, misstating, or omitting a relevant fact in connection with your credentials, the rejection may be reported to The National Practitioner Data Bank.

I authorize the Managed Care Organization to consult with administrators and members of the medical staffs of hospitals or institutions With which I have been or am currently associated, and with others, including, without limit, past and present malpractice carriers, who may have information bearing on my professional competence, character and ethical qualifications. I further consent to the inspection by agents, employees, contractors, affiliates, or other representatives of the Managed Care Organization of all documents that may be material to an evaluation of my professional competence, character, and ethical qualifications. A photocopy of this document shall BE effective.

I release from liability the Managed Care Organization and all representatives of the Managed Care Organization for their acts performed in good faith and without malice or negligence in connection with evaluating my application and my credentials and qualifications, and I release from any liability any and all individuals and organizations who provide information to the Managed Care Organization in good faith and with- out malice or negligence concerning my professional competence, character and ethics. I consent to the release and exchange of information as allowed by law relating to any application, investigation, disciplinary action, suspension or curtailment or participating status, membership and/or privileges of any type to or from the Managed Care Organization.

If I am re-credentialed by the Managed Care Organization, I consent to the Managed Care Organization's inspection of my patient records as allowed by law, necessary for its peer and utilization review and quality assessment purposes and agree to be bound by the Managed Care Organization's participation agreement, credentialing plan, policies, procedures and provider manual.

Signature: ______________________________________ Date: ____________________________

Must be signed in ink.

Each submission requires an original signature and current date. Rubber stamped and electronic signatures are not acceptable.

V. Additional Satellite Office Information

Satellite Office #1 Address: ____________________ ____________________ Office Contact Person: ____________________	Office #1 Phone: ____________________ Office #1 Fax: ____________________ Tax ID (if different): ____________________
Satellite Office #2 Address: ____________________ ____________________ Office Contact Person: ____________________	Office #2 Phone: ____________________ Office #2 Fax: ____________________ Tax ID (if different): ____________________
Satellite Office #3 Address: ____________________ ____________________ Office Contact Person: ____________________	Office #3 Phone: ____________________ Office #3 Fax: ____________________ Tax ID (if different): ____________________
Satellite Office #4 Address: ____________________ ____________________ Office Contact Person: ____________________	Office #4 Phone: ____________________ Office #4 Fax: ____________________ Tax ID (if different): ____________________
Satellite Office #5 Address: ____________________ ____________________ Office Contact Person: ____________________	Office #5 Phone: ____________________ Office #5 Fax: ____________________ Tax ID (if different): ____________________
Satellite Office #6 Address: ____________________ ____________________ Office Contact Person: ____________________	Office #6 Phone: ____________________ Office #6 Fax: ____________________ Tax ID (if different): ____________________

Attestation of Hospital Privileges

Hospital Name	City, State	Statute of Privileges: (Active, Courtesy, Consulting, etc.) *Note: "Pending" or "Applied for" are not acceptable.*	Percentage of Inpatient Admissions

Are your hospital privileges active and in good standing? ☐ Yes ☐ No

If you do not admit, please describe arrangements to provide hospital care:

____

____

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VI. Authorization

I certify that all information contained in this attestation is accurate, complete, and true. I understand that:

A. Any misrepresentation, misstatement, or omission of a relevant fact in connection with this attestation may result in denial of my application or termination of my participation in the network.

B. It is my responsibility to promptly advise BlueCross BlueShield of South Carolina in writing within 30 days of any changes or additions to the information contained in this attestation.

C. All the information contained in this attestation is subject to BlueCross BlueShield of South Carolina's and BlueChoice HealthPlan's investigation and review.

Signature: _______________________________________ Date: _____________________________

Printed Name: ____

Must be signed in ink.

Each submission requires an original signature and current date. Rubber stamped and electronic signatures are not acceptable.