PROVIDER DATA RECORD

PLEASE ENCLOSE THE FOLLOWING CREDENTIALING INFORMATION WITH THIS COMPLETED AND SIGNED FORM.

IF YOU ARE A MEMBER OF **CAQH** AND WOULD LIKE US TO USE THAT APPLICATION, PLEASE PROVIDE US WITH YOUR CAQH ID AND ANY OF THE INFORMATION LISTED BELOW THAT IS NOT ALREADY ATTACHED TO YOUR CAQH APPLICATION.

MISSING INFORMATION WILL DELAY THE CREDENTIALING PROCESS.

___ Completed SC Uniform Managed Care Provider Credentialing Application **OR** CAQH ID number: ____________________

___ Copy of Current State Medical License

___ Copy of Current Federal DEA License

___ Copy of Current State DEA License

___ Copy of Declarations Page of Current Malpractice Insurance/and Patient Compensation Fund Receipt Acknowledgement (if applicable)

___ Current Curriculum Vitae indicating work history for the past 5 years

___ Copy of Clinical Laboratory Improvement Amendment (CLIA) Certificate (If Applicable)

___ Release of Information Form

___ Claim Information Form— If you answered “yes” to any of the malpractice questions, please complete this form or submit a signed written explanation.

___ Hold Harmless Agreement (SCID 505)

___ W-9 Form

___ Signed Provider Participation Amendment, all providers

___ NPI #, please complete on Page 1 of Credentialing Application

SC Uniform Managed Care Provider Credentialing Application

I. PERSONAL INFORMATION

Solo Practice or Group Practice

Name: Last First M.I. Suffix Degree

Maiden and/or other name:

(List W-9 Name if different)

Place of Birth: (City) , (State) Date of Birth:

If you are not a U.S. Citizen, do you have authorization to work in the U.S.? Yes No

Male Female (*OPTIONAL). This information will not be used by the Managed Care Organization in making its determination regarding your participation.*

Social Security Number: NPI: UPIN Number:

Practice Name:

Tax ID Number: Group NPI:

E-mail address of practitioner:

II. MEDICAL LICENSE/REGISTRATION

A. If you are a family practitioner, do you offer OB care? Yes No

B. Do you speak any foreign language fluently that you would like added to the directory? Yes No

If yes, please specify:

C. ECFMG Number:

Current Professional License Number(s) (indicate if not applicable): NA

1. SC Medical License Number: Issue Date: Expiration Date:

2. Additional Medical State Licenses and Numbers:

State: License Number: Issue Date: Expiration Date:

State: License Number: Issue Date: Expiration Date:

State: License Number: Issue Date: Expiration Date:

3. DEA No.: Expiration Date: SC Cont. Drug Perm. No.: Expiration. Date:

History of Previous Licensure in all Jurisdictions (indicate if not applicable): NA

State: License Number: Issue Date: Expiration Date:

State: License Number: Issue Date: Expiration Date:

State: License Number: Issue Date: Expiration Date:

III. EDUCATION/TRAINING/HOSPITAL PRIVILEGES

1. Medical School Institution:

City: State: Country:

Date of Entry: Graduation Date (MMYY): Degree:

Internship Institution: Specialty:

City: State: Country:

Program Completed: Yes No Date of Entry (MMYY): Completion Date (MMYY):

Residency Institution: Specialty:

City: State: Country:

Program Completed: Yes No Date of Entry (MMYY): Completion Date (MMYY):

Fellowship Institution: Specialty:

City: State: Country:

Program Completed: Yes No Date of Entry (MMYY): Completion Date (MMYY):

2. CME REQUIREMENTS:

Number of CME credits completed in the last two years:

3. HOSPITAL STAFF PRIVILEGES

Name:

Address:

Department: Dates of Affiliation: From (MMYY): To (MMYY):

Status of Privileges: % of Admissions:

Additional Hospital Name:

Address:

Department: Dates of Affiliation: From (MMYY): To (MMYY):

Status of Privileges: % of Admissions:

Additional Hospital Name:

Address:

Department: Dates of Affiliation: From (MMYY): To (MMYY):

Status of Privileges: % of Admissions:

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

Provider Initials: **Date:**

IV. MEDICAL SPECIALTIES

MEDICAL SPECIALTIES	CERTIFYING BOARD	DATE CERTIFIED	EXPIRATION DATE
Primary			
If not Board certified, do you plan to take certifying exam?	Yes, Date		No
Secondary			
If not Board certified, do you plan to take certifying exam?	Yes, Date		No

Under which specialty do you wish to be listed in the Directory?

Are you applying for participation as:

Primary Care Physician: Specialist: Non-Physician Practitioner:

V. MALPRACTICE INFORMATION

You are required to maintain malpractice insurance of an adequate and acceptable amount reflective of your specialty as a prerequisite for participating in a managed care organization. Please *attach* a copy of your most recent malpractice insurance binder.

List current and previous malpractice insurance carrier(s) for past five years:

CARRIER NAME/ADDRESS	POLICY NUMBER	EFFECTIVE DATE	EXPIRATION DATE	AMOUNT OF COVERAGE

VI. Five Year Work History *(CV can not be used in lieu of completing this section)*

NAME OF PREVIOUS/CURRENT EMPLOYER(S)	DATE OF EMPLOYMENT (MM/DD/YY-MM/DD/YY)
1.	
2.	
3.	
4.	
5.	

Please provide an explanation of any gaps in employment:

Signature: Date:

RUBBER STAMPED AND ELECTRONIC SIGNATURES ARE NOT ACCEPTABLE

Please print name:

VII. PLEASE ANSWER THE FOLLOWING QUESTIONS (This section must be completed by practitioner)

Managed Care Organizations must have complete liability information and written explanations to begin the credentialing process. *(If you answer "Yes" to any of the questions listed below, please enclose a detailed explanation.)*

	Question		
1.	Do you have any pending misdemeanor or felony charges?	Yes	No
2.	Have you ever been convicted of a felony?	Yes	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?	Yes	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?	Yes	No
5.	Considering the essential functions of a practitioner in your area of practice, in 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?	Yes	No
6.	Have you ever been publicly reprimanded or disciplined by a professional licensing agency or board?	Yes	No
7.	Has your DEA certification or state controlled drug permit ever been restricted, suspended, revoked, voluntarily relinquished or otherwise limited?	Yes	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?	Yes	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?	Yes	No
10.	Has your participation in an Insurance Company network ever been limited or terminated?	Yes	No
11.	In the past five years 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?	Yes	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:	Yes	No
13.	Has any malpractice carrier ever 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.	Has your professional liability insurer ever placed conditions or restrictions on your coverage or ability to obtain coverage?	Yes	No

(THE ABOVE INFORMATION WILL BE HELD STRICTLY CONFIDENTIAL.)

VIII. AUTHORIZATION

I CERTIFY THAT ALL INFORMATION CONTAINED IN THIS APPLICATION 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 its attachments, is subject to the Managed Care Organization's investigation and review and;

D. This is an application only and my submission of this application does not automatically result in participation with the Managed Care Organization;

NOTICE: The National Practitioner Data Bank will be queried if you apply. If your application is rejected for reasons relating to professional conduct or professional competence, which reasons include misrepresenting, misstating, or omitting a relevant fact in connection with your application, 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.

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 without 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 of participation status, membership and/or privileges of any type to or from the Managed Care Organization.

NAME: ____
(print or type)

SIGNATURE: (Applicant) **DATE:**

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.

SC Uniform Managed Care Office Information

I. GENERAL INFORMATION

A. Do you accept Medicaid patients? Yes Medicaid ID number: No

B. Have you signed an agreement to participate with Medicare in the past twelve months? Yes Medicare Group ID number: No

C. Are you accepting new patients? Yes No

D. Are there any age limitations? Yes, Minimum Age: Maximum Age: No

E. Are there gender restrictions? Males Only Females Only Both/ no restrictions

Please describe any other patient limitations:

II. OFFICE INFORMATION

A. Office Address: (physical)

1. Practice Name: EIN# :
2. Street: City: County: State: (Zip)
3. Appointment Phone: Fax:
4. Office Contact Person:
5. Credentialing Contact Phone Number:
6. List of all practitioners (including physician extenders) who are at this location. Indicate (P) for Participating and (A) for applying by each name: If need more room, attach a separate sheet.

Status	Practitioner

7. Do you offer 24-hour/7-day coverage? Yes No Please describe:

8. List physicians who are not a part of your practice with whom you share call:

9. What hours are you available to see patients in this office:

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
From/To							

10. After hours phone number:
11. Is your office equipped with telecommunications devices for the deaf (TDD): Yes No
12. Sign language assistance available: Yes No
13. Languages spoken by office staff:
14. Handicap Access: Yes No

B. Billing Address: (if different)

1. Name claims payable to:
2. Street/PO: City: State: Zip:
3. Phone: Fax:

C. Mailing Address: (if different)

1. Street/PO: City: State: Zip:
2. Phone: Fax:

D. Office e-mail address (if any):

E. Practice Web site address (if any):

ATTACHMENT -FOR EACH ADDITIONAL SATELLITE OFFICE LOCATION, DUPLICATE THIS PAGE

A. Satellite Office Address (physical):

1. Practice Name: EIN#:
2. Street: City: County: State: Zip:
3. Phone: Fax:
4. Office Contact Person:
5. Credentialing Contact Phone Number:
6. List of practitioners (including physician extenders) who are billing at this location. Indicate (P) for Participating and (A) for applying by each name. If need more room, attach a separate sheet.

Status	Practitioner

7. Do you offer 24-hour/7-day coverage? Yes No Please describe:
8. List physicians who are not a part of your practice with whom you share call:
9. What hours are you available to see patients in this office:

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
From/To							

10. After hours phone number:
11. Is your office equipped with telecommunications devices for the deaf (TDD): Yes No
12. Sign language assistance available: Yes No
13. Languages spoken by office staff:
14. Handicap Access: Yes No

B. Billing Address: (if different)

1. Street/PO: City: State: Zip:
2. Phone: Fax:

C. Mailing Address: (if different)

1. Street/PO: City: State: Zip:
2. Phone: Fax:

D. Office e-mail address:

E. Practice Web site address (if any):

CLAIM INFORMATION FORM

If you answered "yes" to any of the malpractice questions, please complete this form or submit a written explanation. Attach any supplemental information necessary. Please copy this form and complete for each additional claim.

1. Patient's Name:______________________________Age:______Sex:________
2. Date of first examination: ____
3. Please describe the pertinent details of the patient's history, examination and care, and the allegations made against you:

   ____
   ____
   ____
   ____

4. Subsequent condition or health of patient:_________________________________
5. Date of Claim:____
6. What Insurance Company, if any, was Involved?__________________________
   Name:____
   Address:____
7. Is Claim Still Pending? ☐ YES ☐ NO
8. Amount of any settlement or judgment:___________________________________
9. Names of other Doctors and Hospital, if any, involved in the Claim or Suit:
   ____
10. Comments: ____

____
____
____

I hereby certify that the above information is, to the best of my knowledge, accurate and complete.

____ _______________

Signature of Applicant Date

Select Health
of South Carolina, Inc.
An AmeriHealth Mercy Company

Credentialing Attestation and Release Form

Applicant agrees to participate in the credentialing/re-credentialing and interviewing program as established by Select Health of South Carolina. Applicant consents to the release of information for the purpose of proper evaluation of his/her professional competence, character, ethics and other qualifications and for resolving any doubts about such qualifications. Applicant agrees that the decision of the Total Quality Management Committee of Select Health shall be final and binding, and to release the plan and its shareholders, respective officers, trustees, agents, employees and all members of the committees of the plan from any and all liability. Applicant further agrees to release from any and all liability any physician, hospital or other person or entity providing information which, but for such waiver, would be privileged and confidential.

Applicant understands that any and all information submitted on or with this form and/or the CAQH Universal Provider Datasource that is found to be false or intentionally misleading may result in rejection or termination with Select Health. Furthermore, a copy of these statements shall be as binding as the original. Applicant also understands that all information submitted on or with this form and/or the CAQH Universal Provider Datasource is subject to investigation and review by Select Health.

Notice: The National Practitioner Data Bank (NPDB) and the Healthcare Integrity and Protection Data Bank (HIPDB) will be queried. If you are not credentialed/re-credentialed for reasons relating to professional conduct or professional competence, the rejection may be reported to the NPDB and/or HIPDB.

Applicant understands and agrees that he/she has the burden of prducing information for proper evaluation of professional competence, character, ethics and other qualifications and for resolving any doubts about such qualifications. Applicant further understands that it is his/her responsibility to notify Select Health in writing within 30 days of any changes or additions to the information submitted on or with this form and/or the CAQH Universal Provider Datasource.

Practitioner Rights

Applicant understands that he/she has the right to:

- Review information obtained through primary source verification for credentialing purposes. This includes information from malpractice insurance carriers and state licensing boards. This does not include information collected from references, recommendations and other peer-review protected information.
- Be notified if any credentialing information is received that varies substantially from application information submitted by the practitioner. The practitioner will be notified of any of the following types of variances: e.g., actions on license, malpractice claim history, suspension or termination of hospital privileges or board-certification decisions with the exception of references, recommendations or other peer-review protected information. The practitioner will have the right to correct erroneous information if the credentialing information received varies substantially from the information that was submitted on his/her application.
- (Upon request) be informed of the status of their application. If the application is current and complete the applicant can be informed of the tentative date that his/her application will be presented to the Credentialing Committee for approval.

I certify that all information included in my application and the accompanying documents are correct and complete to the best of my knowledge.

Provider's Name ______________________________ Date ____________________

Signature ____

Must be signed in ink. ***Each submission requires an original signature and current date. Rubber stamped and electronic signatures are not acceptable.***

Amendment to Select Health of South Carolina, Inc.
Provider Participation

THIS AMENDMENT TO THE PHYSICIAN PARTICIPATION AGREEMENT is made this ___ day of __________, 20____ by and between SELECT HEALTH OF SOUTH CAROLINA, INC.(hereinafter referred to as PLAN) and ____, (hereinafter referred to as PROVIDER.)

WHEREAS PLAN and PROVIDER have duly executed a Physician Participation Agreement (hereinafter AGREEMENT) pursuant to which PROVIDER became obligated to provide certain services to PLAN Members and;

WHEREAS, PLAN desires to amend the terms of the AGREEMENT.

PROVIDER hereby guarantees and certifies that each participating physician, dentist or other licensed non-technician medical provider (hereinafter PARTICIPATING PROFESSIONAL) shall abide by all the terms and conditions of the AGREEMENT and shall require each of its PARTICIPATING PROFESSIONALS to acknowledge their obligations under this AGREEMENT by affixing their signature to this AMENDMENT. Under no circumstances shall PROVIDER allow its PARTICIPATING PROFESSIONALS to provide medical services to any PLAN Member without PARTICIPATING PROFESSIONAL acknowledging their obligations by co-executing this Amendment.

____

Company Name of PROVIDER

____ Date ____________________

PARTICIPATING PROFESSIONAL (Signature)

____

PARTICIPATING PROFESSIONAL (Print or Type)

____

SELECT HEALTH OF SOUTH CAROLINA, INC.

____ Date ____________________

Signature

STATE OF SOUTH CAROLINA
DEPARTMENT OF INSURANCE

HOLD HARMLESS AGREEMENT

In accordance with the requirements of Act No. 83 of 1987, and as a condition of participation as a health care provider in Select Health of South Carolina, Inc., the undersigned Provider (hereinafter "Provider") hereby agrees not to bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have recourse against, enrollees of Select Health of South Carolina, Inc., or persons acting on their behalf, for health care services which are rendered to such enrollees by Provider, and which are covered benefits under enrollees' evidence of coverage. This agreement extends to all covered health care services furnished to the enrollee during the time he is enrolled in, or otherwise entitled to benefits promised by, Select Health of South Carolina, Inc. This agreement further applies in all circumstances including, but not limited to, non-payment by Select Health of South Carolina, Inc. and insolvency of Select Health of South Carolina, Inc. This agreement shall not prohibit collection of copayments from enrollees by Provider in accordance with the terms of the evidence of coverage issued by Select Health of South Carolina, Inc. The Provider further agrees that this agreement shall be construed to be for the benefit of enrollees of Select Health of South Carolina, Inc., and that this agreement supersedes any oral or written contrary agreement now existing or hereafter entered into between the Provider and such enrollees, or persons acting on their behalf.

Provider's Name: ____

Signature: ____

Type Name: ____

Title (if applicable): ____

Date: ____

Form SCID 505