

**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.

PROVIDER

Company Name of PROVIDER

PARTICIPATING PROFESSIONAL
(Signature)

PARTICIPATING PROFESSIONAL
(Print or Type)

DATE: _____

SELECT HEALTH of SC, INC.

Cindy Helling

SELECT HEALTH OF SC, Inc

SIGNATURE

DATE: _____