

## Organization Information

Agency/Organization name \_\_\_\_\_

Federal tax ID # \_\_\_\_\_ NPI # \_\_\_\_\_

Medicaid provider # \_\_\_\_\_ Medicare provider # \_\_\_\_\_

Does your organization do business under another name?  Yes  No If yes, what name? \_\_\_\_\_

Type of facility or provider:

Hospital  Home health agency  Skilled nursing/LTC facility  Ambulatory surgery center  Behavioral health facility

Laboratory  Home infusion agency  Radiology center  Physical therapy center  Occupational therapy center

DME supplier  Audiology center  Speech therapy center  Other (please specify) \_\_\_\_\_

Covered services to be provided (attach additional sheets as needed): \_\_\_\_\_

## Payee Information

Payee name (as it should appear on checks) \_\_\_\_\_

Billing address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Contact person \_\_\_\_\_ Title \_\_\_\_\_ Phone \_\_\_\_\_

E-mail \_\_\_\_\_ Fax \_\_\_\_\_

## Credentialing Contact Information

Contact organization \_\_\_\_\_

Mailing address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Contact person \_\_\_\_\_ Title \_\_\_\_\_ Phone \_\_\_\_\_

E-mail \_\_\_\_\_ Fax \_\_\_\_\_

### ATTESTATION & RELEASE

On behalf of the Facility/Ancillary Agency, I hereby certify that:

- All information included in this application and the accompanying documents are correct and complete to the best of my knowledge and belief. Furthermore, I understand and agree that I have the burden of producing information concerning the organization's qualifications and for resolving any doubts about such qualifications.
- If this application contains either any material omission or false or misleading information, I understand that participation with Select Health may be rejected or

terminated. I further understand that a copy of these statements shall be as binding as the original.

- In the event that there are any changes to any of the information provided in this application, Select Health will be notified in writing within 30 days.

On behalf of the Facility/Ancillary Agency, I hereby authorize Select Health to verify the information provided on this application and accompanying documentation. I also authorize the release of any relevant information pertaining to organizational status, licensure, accreditation, or operations to Select Health.

I understand that the Healthcare Integrity and Protection Data Bank (HIPDB) will be queried. I further understand

that if the facility is not credentialed or recredentialed for reasons relating to professional conduct or professional competence, the rejection may be reported to the HIPDB.

I agree that the decision of the Total Quality Management Committee of Select Health shall be final and binding, and I release Select Health, its shareholders, respective officers, trustee, agents, employees and all members of the Committees of the Select Health from any and all liability. I authorize Select Health to use the information provided in their selection, credentialing and recredentialed process, and to verify such information as appropriate.

## Authorized Signature

Authorized signature for provider \_\_\_\_\_ Date \_\_\_\_\_

Print name \_\_\_\_\_ Title \_\_\_\_\_

Each submission requires an **ORIGINAL SIGNATURE** in ink and **CURRENT DATE**. Rubber-stamped and electronic signatures are not acceptable.  
**Practitioners have the right to review information obtained to evaluate their credentialing and re-credentialing applications.**

## Facility Location

**PLEASE DUPLICATE THIS PAGE FOR ADDITIONAL LOCATIONS**

Office name \_\_\_\_\_ Tax ID # \_\_\_\_\_

Physical address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Mailing address (if different) \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Office contact \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_

Hours of operation	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
From — To							

## Licensure/Certification *Please include copies of all licenses and certificates*

Medicaid provider # _____	NPI # _____		If N/A, please explain: _____ _____ _____ _____ _____ _____ _____
Medicare provider # _____	Medicare certification _____	<input type="checkbox"/> N/A	
State (DHEC) license # _____	Expiration date _____	<input type="checkbox"/> N/A	
Business/Retail license # _____	Expiration date _____	<input type="checkbox"/> N/A	
Pharmacy permit # _____ <small>Home infusion only</small>	Expiration date _____	<input type="checkbox"/> N/A	
CLIA certificate # _____ <small>Lab only</small>	Expiration date _____	<input type="checkbox"/> N/A	
Medical gasses permit # _____ <small>If compressed air is provided</small>	Expiration date _____	<input type="checkbox"/> N/A	
FDA certification for mammography services	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> N/A	
State inspection certificates for x-ray equipment	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> N/A	

## Professional Liability Coverage *Please include copy of liability face sheet*

Insurer \_\_\_\_\_

Policy # \_\_\_\_\_ Policy limits \_\_\_\_\_ Policy period \_\_\_\_\_

## Accreditation *Please include copy of certificate* N/A

Accrediting body \_\_\_\_\_ Expiration date \_\_\_\_\_

Date of most recent survey \_\_\_\_\_ Date of next survey \_\_\_\_\_

**For hospital, home health, skilled nursing, ambulatory surgical centers and behavioral health facilities:  
if non-accredited, please provide a copy of a CMS or state site visit.**