

# Non-Contracted Provider Information Sheet

Please indicate the appropriate request box. Return form electronically to [Teresa.Simmons@selecthealthofsc.com](mailto:Teresa.Simmons@selecthealthofsc.com) or via fax to **843.569.0702**. You can click the button below to submit the form electronically.

- UM Request\***
- Standard request for updates**

UM Representative Name \_\_\_\_\_ Phone # \_\_\_\_\_ Date \_\_\_\_\_

	PROVIDER INFORMATION		GROUP/FACILITY INFORMATION
<b>Full name</b> (include credentials MD, DO, NP, CRNA, etc.)			
<b>Tax ID #</b>			
<b>Social Security #</b>			
<b>Medicaid #</b> (6 digits)	(Will not start with GP)		
<b>UPIN #</b>			
<b>Speciality</b> (CRNA/EM)			
<b>Federal DEA #</b> (ex. AA 123456)			
<b>NPI #</b>			
<b>Board certification</b>			
<b>Other languages</b>			
<b>Sex   Race</b>	Sex	Race	
<b>Hospital affiliations</b>			

## Payee Information

Name \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_

Billing Address, city, state zip \_\_\_\_\_

Contact name \_\_\_\_\_ Contact phone \_\_\_\_\_

## Practice Physical Location & Information

Name \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_

Physical Address, city, state zip \_\_\_\_\_

Contact name \_\_\_\_\_ Contact phone \_\_\_\_\_

Hours of operation	M	Tu	W	Th	F	Sa	Su
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\*UM Requests must be submitted within 1 BUSINESS DAY after initial contact with Select Health UM Department or authorization is subject to denial. For additional providers and locations, please attach an additional copy of this form for each individual provider with all information filled out. Provider agrees to accept the Medicaid Allowable and not balance-bill the member.

