Select Health of South Carolina

Healthy Connections

Non-Contracted Provider Information Sheet

Please indicate the appropriate request box. Return form to **networkopsprovider@selecthealthofsc.com** or fax to **1-855-316-0093.** Click the **SUBMIT** button at the bottom of this form to send via email.

Note: SUBMIT function works best with Internet Explorer.

☐ **UM Request*** ☐ **Standard request for updates**

Please complete this form in its entirety.

UM representative name: _____ Phone: _____ Date: _____

	Provider Information		Group/Facility Information
Full name (include credentials MD, DO, NP, CRNA, etc.)			
Tax ID number			
Social Security number			
Medicaid number (six digits)	(will not start with GP)		
UPIN number			
Specialty (CRNA/EM)			
Federal DEA # (eg, AA 123456)			
NPI number			
Board certification			
Other languages			
Sex | Race	Sex	Race	
Hospital affiliations			

Payee Information		
Name:	Phone:	Fax:
Billing address, city, state, ZIP code:		
Contact name:		Contact phone:

Practice Physical Location and Information							
Name:				Phone:		Fax:	
Physical address, city, state, ZIP code:							
Contact name:					Contact phone:		
Hours of operation	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

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Ownership Disclosure

The South Carolina Department of Health and Human Services (SCDHHS) requires all providers who do not have a South Carolina Medicaid ID to submit ownership and control information, including information on agents or managing employees of the provider.

- A link to the SCDHHS ownership disclosure form is located on the Select Health website at: State of South Carolina Ownership Disclosure form.
- Please also include a copy of your W-9 form.

Note: Failure to submit this information will result in nonpayment of your claims.

***UM requests must be submitted within ONE 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.

SUBMIT