Select Health of South Carolina | Healthy Connections

Provider Application Checklist

Please see the checklist below and enclose all of the necessary information. Thank you.
MISSING INFORMATION WILL DELAY THE CREDENTIALING PROCESS.

Product: ☐ Medicaid ☐ Medicare/Medicaid Plan Provider type: ☐ PCP ☐ Specialist ☐ Both

Provider name: _____ Practice name: _____

Check enclosed items	SHSC use only	Provider Application Items
☐	☐	SC Uniform Managed Care Provider Credentialing Application
		OR
☐	☐	CAQH ID# _____ *All required documents must either be attached to the CAQH record or submitted to your account executive. Attestation date should be no older than 90 days.*
☐	☐	Copy of current state medical license
☐	☐	Copy of current state CDS license
☐	☐	Copy of current federal DEA license
☐	☐	Credentialing Attestation and Release form
☐	☐	Signed amendment to the SHSC Provider Participation Agreement
☐	☐	Ownership Disclosure form (SCDHHS Form 1514)
☐	☐	Medicaid # _____
☐	☐	Medicare # *(if applicable)* _____
☐	☐	Or Proof of filing
☐	☐	NPI# _____
☐	☐	Group NPI# _____
☐	☐	W-9 form

Check enclosed items	SHSC use only	Provider Application Items
☐	☐	Hours of operation
☐	☐	Remit address
☐	☐	Hospital admitting privileges or arrangements
☐	☐	Claim Information Form *If you answered 'yes' to any of the malpractice questions, please complete form or submit a signed written explanation.*
☐	☐	Copy of declarations page of current malpractice insurance and patient compensation fund receipt acknowledgement *(if applicable)*
☐	☐	Copy of Clinical Laboratory Improvement Amendment (CLIA) Certificate *(if applicable)*
☐	☐	Current CV inicating work history for the past 5 years
☐	☐	For Nurse Practitioners: Nurse Protocols *Must be dated within 1 year, signed by NP and physician preceptor.*
☐	☐	For Physician Assistants: Scope of Practice *If signed more than 1 year ago, written confirmation is required to confirm scope is still current.*
☐	☐	Race, Ethnicity and Language Data form
☐	☐	Hold Harmless Agreement (SCID 505)
☐	☐	Moral and Religious Objections form *(if applicable)*
☐	☐	Signed Provider Participation Agreement
☐	☐	Provider Add Request Form

For Select Health use only: ☐ Site Visit (PCP and OB/GYN practitioners only) for new contracts or new locations.
All PCP and OB/GNYN addresses listed on the application must have a site visit.

Practice Name	Location	Review Date