Select Health of South Carolina

Facility/Ancillary/Provider Credentialing Application

Organization Information

Agency/Organization name ______________________

Federal tax ID # ______________________ NPI # ______________________

Medicaid provider # ______________________ Medicare provider # ______________________

Does your organization do business under another name? __________ 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 (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 recredentialing 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.

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Facility/Ancillary/Provider Credentialing Application

Facility Location

Agency/Organization name ______________________

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 From — To	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

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

Medicaid provider # ______________________ NPI # ______________________ If N/A please explain:

Medicare provider # ______________________ Medicare certification ____________ ☐ N/A ____________

State (DHEC) license # ______________________ Expiration date ____________ ☐ N/A ____________

Business/Retail license # ______________________ Expiration date ____________ ☐ N/A ____________

Pharmacy permit # *(home infusion only)* ______________________ Expiration date ____________ ☐ N/A ____________

CLIA certificate # *(lab only)* ______________________ Expiration date ____________ ☐ N/A ____________

Medical gases permit # *(if compressed air provided)* ______________________ Expiration date ____________ ☐ N/A ____________

FDA certification for mammography services ☐ Yes ☐ No ☐ N/A ____________

State inspection certificates for x-ray equipment ☐ Yes ☐ No ☐ 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.

HEALTH PLAN NCQA ACCREDITATION EXCELLENT MEDICAID