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**. You can click the button below to submit the form by email.

Submit

☐ **UM Request***

☐ **Standard request for updates**

UM Representative Name _____ Phone # _____ Date _____

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

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

***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.