Contract Initiation Application

A. PROVIDER DEMOGRAPHIC INFORMATION

Facility/Group Name: _____

Professional Category (Specialty): _____

Address: _____ City: _____ ST: _____ Zip: _____

Phone Number: (___) _____ Fax Number: (___) _____

Office Contact: _____ Office Contact Telephone: _____

Email Address: _____

Hours of Operation: _____ ☐ **Mon.** ☐ **Tues.** ☐ **Wed.** ☐ **Thur.** ☐ **Fri.** ☐ **Sat.** ☐ **Sun:** _____

Federal Tax ID Number: _____ SC Medicaid Provider Number(s): _____

Medicare Provider Number(s): _____ Medicare Certification Number: _____

National Practitioner Identification Number: _____

Multiple Office Location(s) (Attach additional pages if more than three locations.)

1. Street Address: _____

City: _____ State: ___ Zip: _____ Phone: _____ Fax: _____

NPI Number: _____

2. Street Address _____

City: _____ State: ___ Zip: _____ Phone: _____ Fax: _____

NPI Number: _____

3. Street Address _____

City: _____ State: ___ Zip: _____ Phone: _____ Fax: _____

NPI Number: _____

Billing office (if different from primary office information above)

Street Address: _____

City: _____ State: ___ Zip: _____ Phone: _____ Fax: _____

***Please include a Disclosure of Ownership Part 2 along with a Roster of all locations to include Group NPI(s) listed above and a W-9.**

- ❑ **Delegated**

LANGUAGES spoken (other than English): _____

B. TYPE OF FACILITY/GROUP

□ ANCILLARY

- ❑ Free Standing Surgical Center
- ❑ Free Standing Rehabilitation Facility
- ❑ Home Health Agency
- ❑ Durable Medical Equipment
- ❑ Home Infusion
- ❑ Dialysis
- ❑ Chemotherapy
- ❑ Imaging/Radiology
- ❑ Physical Therapy
- ❑ Home Community Base Service
- ❑ Outpatient Rehabilitation Facility
- ❑ Private Duty Nursing Agency
- ❑ Laboratory
- ❑ Ambulatory
- ❑ Urgent Care

□ GROUP PRACTICE (ATTACH ROSTER)

- ❑ PCP
- ❑ Specialist

□ CLINIC

- ❑ Skilled Nursing Facility
- ❑ Federally Funded Health Clinic
- ❑ Federally Qualified Health Clinic
- ❑ Rural Health Clinic
- ❑ Clinic

□ HOSPITAL

□ OTHER: _____

Provider Network Specialist Signature: _____ **Date:** _____

C. RELEASE OF INFORMATION AND ATTESTATION

I AGREE:

1. To assist the Credentialing Department and its representatives in gathering the information necessary to credential my facility. In this regard, I recognize that I have the burden of resolving any reasonable doubts about the facility's credentials;

2. To be bound by the terms of the contract in all matters relating to the consideration of this application. If an adverse ruling is made with respect to the facility's credentials, the facility will exhaust the administrative remedies afforded by the Contract and Provider Manual before resorting to formal legal action.

3. To release from liability any persons or entities that provide information in furtherance of the above-described purposes, to the fullest extent allowed by applicable statutes, regulations, and judicial decisions.

4. To update this application while it is being processed should there be any change in the information provided that could affect the application or its outcome.

I hereby attest that the information furnished by me to the Corporate Credentialing Department is true and complete to the best of my knowledge and is furnished in good faith. I fully understand that any significant misstatement in, or omission from this application will constitute cause for denial or revocation of membership.

I present this application, and arrange for the submission of other information as part of the credentialing process, in the expectation that confidentiality and privacy will be preserved, and that the information will only be used for medical staff credentialing, peer review, and Quality Improvement activities.

Signature:	
Printed Name:	**Date:**