FirstChoice℠
by Select Health of South Carolina
FAMILY OF HEALTH PLANS

Provider Contract/Amendment Inquiry Form

Currently participating in the First Choice by Select Health of South Carolina (Medicaid) network ☐

Please select all plans you would like to join:

☐ First Choice by Select Health of South Carolina (Medicaid)
☐ First Choice Next (individual and family health plans both on and off the Exchange [ACA])
☐ First Choice VIP Care (Medicare Advantage dual-eligible special needs plan [D-SNP])
☐ First Choice VIP Care Plus (Medicaid Medicare plan)
☐ All

Date:

Completed form should be returned to your Account Executive or **scprovidernetworkrequest@selecthealthofsc.com**.

Specialty:

☐ Primary care provider (PCP)
☐ Specialist
Specialty:
☐ Ancillary
☐ Behavioral health
☐ Hospital
☐ Dental
☐ Vision
☐ Other:

Group or provider information

Legal entity name (W9):	
Tax ID number (TIN):	Group NPI:
CAQH number:	Medicaid number:
Legal entity signatory:	Medicare/CCN number:
Legal entity signatory title:	

Notice correspondence information

Legal notice mailing address, including contact name:

Contact information for contract processing

Contact name:	Title:
Mailing address:	County:
☐ Check if primary address is the same as the mailing address.	
Contact phone:	Contact email:

Assignment of payment

Compensation payable by First Choice Next is payable to the TIN and address above. ☐ Yes ☐ No

If **no**, payment is to be assigned to:

Name:	TIN:
Address:	