Select Health of South Carolina Healthy Connections

Credentialing Attestation and Release Form

Applicant agrees to participate in the credentialing/re-credentialing and interviewing program as established by Select Health of South Carolina. Applicant consents to the release of information for the purpose of proper evaluation of his/her professional competence, character, ethics and other qualifications and for resolving any doubts about such qualifications. Applicant agrees that the decision of the Total Quality Management Committee of Select Health shall be final and binding, and to release the plan and its shareholders, respective officers, trustees, agents, employees and all members of the committees of the plan from any and all liability. Applicant further agrees to release from any and all liability any physician, hospital or other person or entity providing information which, but for such waiver, would be privileged and confidential.

Applicant understands that any and all information submitted on or with this form and/or the CAQH Universal Provider Datasource that is found to be false or intentionally misleading may result in rejection or termination with Select Health. Furthermore, a copy of these statements shall be as binding as the original. Applicant also understands that all information submitted on or with this form and/or the CAQH Universal Provider Datasource is subject to investigation and review by Select Health.

Notice: The National Practitioner Data Bank (NPDB) and the Healthcare Integrity and Protection Data Bank (HIPDB) will be queried. If you are not credentialed/re-credentialed for reasons relating to professional conduct or professional competence, the rejection may be reported to the NPDB and/or HIPDB.

Applicant understands and agrees that he/she has the burden of producing information for proper evaluation of professional competence, character, ethics and other qualifications and for resolving any doubts about such qualifications. Applicant further understands that it is his/her responsibility to notify Select Health in writing within 30 days of any changes or additions to the information submitted on or with this form and/or the CAQH Universal Provider Datasource.

Practitioner Rights

Applicant understands that he/she has the right to:

- Review information obtained through primary source verification for credentialing purposes. This includes information from malpractice insurance carriers and state licensing boards. This does not include information collected from references, recommendations and other peer-review protected information.
- Be notified if any credentialing information is received that varies substantially from application information submitted by the practitioner. The practitioner will be notified of any of the following types of variances: e.g., actions on license, malpractice claim history, suspension or termination of hospital privileges or board-certification decisions with the exception of references, recommendations or other peer-review protected information. The practitioner will have the right to correct erroneous information if the credentialing information received varies substantially from the information that was submitted on his/her application.
- (Upon request) be informed of the status of their application. If the application is current and complete the applicant can be informed of the tentative date that his/her application will be presented to the Credentialing Committee for approval.

I certify that all information included in my application and the accompanying documents are correct and complete to the best of my knowledge.

Provider's Name _____ Date _____

Signature _____

Must be signed in ink. ***Each submission requires an original signature and current date. Rubber stamped and electronic signatures are not acceptable.***