Healthy Connections
VISUAL GUIDE

❯ Online Enrollment Application

SOUTH CAROLINA
Healthy Connections
MEDICAID

Contents

Quick Start Overview

Follow these steps to enroll in South Carolina Medicaid via the online enrollment process.

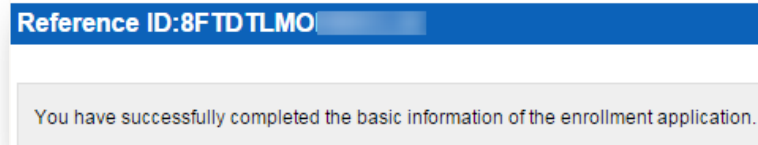1. Access the online enrollment application at provider.scdhhs.gov

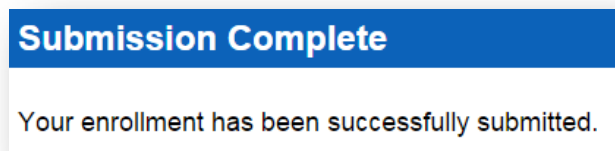2. Enter some preliminary basic information.

3. Obtain a Reference ID #.

4. Complete more information about your business.

5. Review and submit your application.

Start an Application

Go to provider.scdhhs.gov and select Online Enrollment Application.

Click *Begin a New Enrollment* to get started.

Provider Enrollment

Individuals, Organizations, Atypical Individuals, Atypical Organizations, Ordering/Referring providers as well as currently enrolled providers adding a new location can enroll into the system. A unique Reference ID is assigned to each application. Emails containing the Reference ID will be sent to both the authorized individual completing the application and the provider. The Reference ID is required to retrieve a saved application and to correct or update enrollment information after the application is approved. If the application is not completed and submitted at the time the Reference ID is issued, the provider has thirty (30) calendar days from the issuance date of the Reference ID in which to log back into the online application and complete the submission or the record will be deleted from the system.

Who Can Enroll

Individual Provider

-- An individual provider is a person enrolled directly who provides health services to health care members. An individual may bill independently for services or may have an affiliation with an organization. Individuals enrolling in SCDHHS Medicaid program are required to submit their Social Security Number (SSN) and National Provider Identifier (NPI).

Individual/Sole Proprietor

-- An Individual/Sole proprietor is a person enrolled directly who provides health services to health care members. An individual may bill independently for services or may have an affiliation with an organization. An Individual/Sole proprietor enrolling in SCDHHS Medicaid program is required to submit their Social Security Number (SSN) and National Provider Identifier (NPI).

For SCDHHS individual Medicaid enrollment, type of ownership defaults to Individual/Sole Proprietor when an EIN is submitted on the application. As a sole proprietor, you would need to obtain an identification number if either of the following apply; (1) pay wages to one or more employees, or (2) you file pension or excise tax returns. If these conditions do not apply, your SSN is your taxpayer identification number.

Ordering/Referring Providers

-- All providers of health care services may be ordering/referring providers but not all ordering/referring providers are billing providers. In an effort to capture all providers who order services and/or refer Medicaid beneficiaries for services and who do not submit claims to SCDHHS for payment, ordering/referring providers are required to enroll. All ordering/referring providers are required to have an NPI and that NPI must be submitted on the claims as the ordering/referring provider. All claims will be subject to denial if the ordering/referring NPI is not on the claim and/or the ordering/referring provider is not enrolled in SCDHHS Medicaid program. Examples of ordering/referring providers are Physicians, a Licensed Nurse Practitioners, and Certified Midwives.

Organization

-- Any entity, agency, facility or institution that provides health services to health care members. An organization may bill independently for services performed or may be an affiliation of individual providers. Organizations enrolling in SCDHHS Medicaid program are required to submit their Employer Identification Number (EIN) and NPI.

Atypical Providers

-- CMS defines atypical providers as "providers that do not provide health care, as defined under HIPAA in Federal regulations at 45 CFR section 160.103." Providers who perform home and vehicle modifications, respite services, and attendants working in Community Long Term Care (CLTC) facilities are examples of atypical providers reimbursed by the Medicaid program. Even if these atypical providers submit HIPAA transactions, they still do not meet the HIPAA definition of health care and therefore cannot receive an NPI.

Atypical Individual

-- An Atypical Individual provider is a person enrolled directly who provides non-health related services to health care members. An atypical individual may bill independently for services or may have an affiliation with an organization. Individuals enrolling in SCDHHS Medicaid program are required to submit their Social Security Number (SSN). The provider may or may not be eligible for an NPI and NPI is not required.

Atypical Organization

-- An Atypical Organization provider is a facility, agency, entity, institution, clinic or group of providers enrolled directly who provide non-health related services to health care members. An atypical organization may bill independently for services or may have an affiliation with an individual. Organizations enrolling in SCDHHS Medicaid program are required to submit their Employer Identification Number (EIN). The provider may or may not be eligible for an NPI and NPI is not required.

Add a Location

-- Organizations (facilities, agencies, groups, etc.) enrolled with a unique combination of an Employer [...] existing enrollment. The location being added must operate under the same EIN/NPI as the previously [...] application fee. When the EIN/NPI combination is not the same as a previously enrolled location, provi[...]

Change Request

-- Providers successfully enrolling as a SC Medicaid provider through the web application are able to s[...] Providers will not be able to make changes to submitted enrollment applications until after the application is approve[...] such has been received by the provider.

Revalidation Request

-- Participating providers(Individuals and Organizations) enrolled on or before December 02 [...] must have their enrollment information revalidated. The enrolled information will be verified and screened to ensure compliance according to the patient protection and A[...]able Care Act of the provider enrollment and screening regulations published by the Centers for Medicare and Medicaid services.

Begin a New Enrollment

| Begin a New Enrollment | Continue an Existing Enrollment | Enrollment Revalidation | Change Request |

Choose Enrollment Type
Choose *New Enrollment*.

Provider Services Menu

Required fields are marked with an asterisk (*).

Please choose the option that best describes your intent: *

(•) New Enrollment   ( ) Add a Location

Enrollment Type* | Individual ▼ |

Medicaid Service Area (MSA) Determination:

Please choose the State of your Primary Practice Location *: | SC ▼ |

The Medicaid Service Area determination is In-State.

Individual Information

Select *Provider Information*.

Provider Enrollment-Individual
Enrollment Progress

| Provider Information | Provider Type & Specialty | Location Information | Licenses & Certificates | Taxonomy & Relationships | Ownership, Associations & Affiliations | Sanctions, Trading Partners, W-9 &EFT | Terms & Conditions/ Review & Submit |

Enter your Personal Information.

Provider Information

Required fields are marked with an asterisk (*).

Are you enrolled in Medicare? *:   ○ Yes   ○ No

Are you enrolled in Other State's Medicaid/CHIP? *:   ○ Yes   ○ No

Enter your name as entered on your IRS income tax return.

Provider First Name *	
Provider Last Name *	
Provider Middle Name	
Social Security Number *	
National Provider Identifier (NPI) *	
Suffix	-- Select One -- ▾
Title (Mr.,etc)	-- Select One -- ▾
Date of Birth (mm/dd/yyyy) *	
Provider Gender *	-- Select One -- ▾
Contact Email Address *	
Re-enter Contact Email Address *	
Providers Email Address *	
Re-enter Providers Email Address *	

Do you report your income using an Employer Identification Number (EIN)? *   ○ Yes   ○ No

Do you operate under a trade or company name, e.g. John K. Provider doing business as name (DBA) Provider Family Practice? *   ⦿ Yes   ○ No

Doing Business As Name (DBA) Information

Doing Business As Name (DBA) *	
Years doing business under this name *	

Have you used a different Doing Business As Name (DBA)? *   ○ Yes   ○ No

Reference ID

Receive a Reference ID, useful to retrieve your saved application for the next 30 days.

More information about your business

Complete each section of the application.

Provider Type & Specialty

Provider Type and Specialty/Sub Specialty
Select your provider type and specialty.

Provider Type and Specialty/Subspecialty

Required fields are marked with an asterisk (*).

After selecting the appropriate Provider Type in the first menu, the associated specialty information will then appear in the next menu.

Please select a Provider Type, Specialty and Subspecialty from the following drop-down lists that best describe the services you will be rendering.

Provider Type *:	Physician, Osteopath Individual
Primary Specialty *:	Oncology
Primary Subspecialty:	No Subspecialty
Secondary Specialty:	Pathology
Secondary Subspecialty :	No Subspecialty

Location Information

Primary Practice Location
Provide your primary practice location.

Primary Practice Location

Required fields are marked with an asterisk (*).

This is the physical location where service will be rendered, or in the case of mobile services, where management/supervision occurs. (P.O. Box or P.O. Drawer is not acceptable as a location address.)

Street *	
Street Line 2	
City *	
State/Province	SC
County *	-- Select One --
Zip Code/Postal Code *	ZIP CODE Look-Up

Contact Person

Provide a contact person.

Provider Contact Person

Individual authorized to receive information or make business decisions on behalf of the applying provider.

Provider Contact First Name *

Provider Contact Last Name *

Provider Contact Middle Name

Suffix   -- Select One --

Telephone Number *   Telephone Number Extension

Other Telephone Number   Other Telephone Number Extension

Fax Number

Email Address *

Re-enter Email Address *

Does the contact person have a managing relationship to the applicant? If yes, this person will be included in the Managing Relationship section of this application.*
◉ Yes   ○ No

Social Security Number *

Date of Birth (mm/dd/yyyy) *

Business Relationship to Enrolling Provider *   -- Select One --

Familial Relationship to Enrolling Provider *   -- Select One --

Hours of Operation

Enter your hours of operation.

Day	Hour							Copy Hours
Monday *	-- Select One -- ▼	to	-- Select One -- ▼	--and--	-- Select One -- ▼	to	-- Select One -- ▼	☐ Closed	☐ Copy Hours
Tuesday *	-- Select One -- ▼	to	-- Select One -- ▼	--and--	-- Select One -- ▼	to	-- Select One -- ▼	☐ Closed	☐ Copy Hours
Wednesday *	-- Select One -- ▼	to	-- Select One -- ▼	--and--	-- Select One -- ▼	to	-- Select One -- ▼	☐ Closed	☐ Copy Hours
Thursday *	-- Select One -- ▼	to	-- Select One -- ▼	--and--	-- Select One -- ▼	to	-- Select One -- ▼	☐ Closed	☐ Copy Hours
Friday *	-- Select One -- ▼	to	-- Select One -- ▼	--and--	-- Select One -- ▼	to	-- Select One -- ▼	☐ Closed	☐ Copy Hours
Saturday *	-- Select One -- ▼	to	-- Select One -- ▼	--and--	-- Select One -- ▼	to	-- Select One -- ▼	☐ Closed	☐ Copy Hours
Sunday *	-- Select One -- ▼	to	-- Select One -- ▼	--and--	-- Select One -- ▼	to	-- Select One -- ▼	☐ Closed	☐ Copy Hours

After-Hours Coverage

Enter your after-hours information.

After-Hours Coverage

Type of after-hours or 24/7 responder coverage*
- ☐ Answering Service
- ☐ Answering Machine that gives the number of the provider to call
- ☐ Hospital operator who pages on-call provider
- ☐ Call forward or stay-on-line transferring
- ☐ Nurse Triage Service
- ☐ 24 hour Hospital Switchboard
- ☐ ER Triage
- ☐ Physician on call
- ☐ Other

Correspondence Address Information
Enter your correspondence information.

Correspondence Address Information

Accounting Correspondence/Pay To Address Information

This is the address where all paper and accounting correspondence is to be mailed and the email address where electronic correspondence will be sent.

Required fields are marked with an asterisk (*).

☐ Check this box if the correspondence person is the same as the Authorized Individual entered earlier.
☐ Check this box if the correspondence address is the same as the physical address entered earlier.

Organization/Business Name	
First Name *	
Last Name *	
Middle Name	
Suffix	-- Select One -- ▼
Office Phone # *	Ext
Fax Number	
Corresponding email address *	
Re-enter corresponding email address *	
Street *	
Street Line 2	
City *	
State/Province *	-- Select One -- ▼
Zip Code/Postal Code *	ZIP CODE Look-Up

Enter your contact person.

Provider Contact Person

☐ Check this box if the correspondence contact is the same as the Authorized Individual entered earlier.
☐ Check this box if the correspondence contact address is the same as the physical address entered earlier.

First Name *	[ ]
Last Name *	[ ]
Middle Name	[ ]
Suffix	-- Select One -- ▾
Office Phone # *	[ ] **Ext** [ ]
Fax Number	[ ]
Corresponding email address *	[ ]
Re-enter corresponding email address *	[ ]
Street *	[ ]
Street Line 2	[ ]
City *	[ ]
State/Province *	-- Select One -- ▾
Zip Code/Postal Code *	[ ] ZIP CODE Look-Up

Does the contact person have a managing relationship to the applicant? If yes, this person will be included in the Managing Relationship section of this application.*
◉ Yes ○ No

Social Security Number *	[ ]
Date of Birth (mm/dd/yyyy) *	[ ]
Business Relationship to Enrolling Provider *	-- Select One -- ▾
Familial Relationship to Enrolling Provider *	-- Select One -- ▾

Services

Explain which services apply to you.

Interpretation Services

Are Oral Interpretation services available? ○ Yes   ○ No
Is Braille supported? ○ Yes   ○ No
Is sign Language supported? ○ Yes   ○ No

Languages Supported

Languages Supported *
- ☐ English
- ☐ Spanish
- ☐ French
- ☐ German
- ☐ Italian
- ☐ Chinese
- ☐ Tagalog

Special Needs

Please check all that this location is equipped to serve.
- ☐ Blind/Visually Impaired
- ☐ Deaf/Hearing Impaired
- ☐ Physically Handicapped
- ☐ Sexually Aggressive
- ☐ Behaviorally Disruptive

Is this location TDD/TTY Equipped? ○ Yes   ○ No

New Patients Accepted

Are you accepting new patients? ○ Yes   ○ No
Do you accept siblings of established patients? ○ Yes   ○ No

Age and Gender Served

Male
- ☐ 0-3
- ☐ 3-12
- ☐ 12-18
- ☐ 18-60
- ☐ 60 and Above

Female
- ☐ 0-3
- ☐ 3-12
- ☐ 12-18
- ☐ 18-60
- ☐ 60 and Above

Licenses, Certifications & Accreditation

License Details

Add any licenses you have.

License Details

Required fields are marked with an asterisk (*).

Are you a board certified or board eligible physician? * ○ Yes ○ No

Provider Type/Education

Provider Type/Education (Select One)	-- Select One -- ▼

License Information

Add a license by filling out the fields below. You may add as many licenses as needed.

License Type *	-- Select One -- ▼
License Category *	-- Select One -- ▼
License *	-- Select One -- ▼
State/Province *	-- Select One -- ▼
License # *	
Effective Date # *	
Expiration Date # *	

Add License

Existing Licenses

License Type	License Certification	License	State/Province	License#	Effective Date	Expiration Date	Delete
Professional (Board)	Anesthesiologist Assistant	Anesthesiologist Assistant	SC	231321	01/01/2015	01/01/2016	⊖

Certification

Add any certifications you have.

Certification

Required fields are marked with an asterisk (*).

Do you prescribe medications? *:   ○ Yes   ○ No

Do you prescribe covered items or services other than medications? *:   ○ Yes   ○ No

Add a certification by filling out the fields below. You may add as many certifications as needed .

Certification Type	-- Select One -- ▼
Certifying Entity	-- Select One -- ▼
Certification #	
Effective Date	
Expiration Date	

[Add Certification]

Existing Certifications

Certification Type	CLIA Certification Type	Certifying Entity	Certification #	Effective Date	Expiration Date	Delete
CLIA	Certification of Accreditation	CMS Division of Laboratory Services within the Certification and Survey Group	32132	01/01/2015	01/01/2016	⊖

Taxonomy & Relationships

Taxonomy Code
List any taxonomy codes that apply to you.

Taxonomy Code

Taxonomy

Please enter the applicable taxonomy code(s). A maximum of fifteen (15) codes may be entered.

If you do not know your taxonomy code(s), you may access a taxonomy code set by clicking the following link, Taxonomy Codes. Copy and paste the appropriate taxonomy code(s) into the text fields below.

Taxonomy 1 *		Taxonomy 9	
Taxonomy 2		Taxonomy 10	
Taxonomy 3		Taxonomy 11	
Taxonomy 4		Taxonomy 12	
Taxonomy 5		Taxonomy 13	
Taxonomy 6		Taxonomy 14	
Taxonomy 7		Taxonomy 15	
Taxonomy 8			

Managing Relationships
Disclose any managing relationships

Managing Relationships

Managing Relationships

As required by 42 CFR 1002.3, the provider must disclose the following for each individual officer, director, managing employee(general manager, business manager, administrator).

Failure to provide the required information may result in a denial for participation.

List Managing Relationships *

Relationship

First Name *	[ ]
Last Name *	[ ]
Middle Name	[ ]
Social Security Number *	[ ]
Suffix:	-- Select One -- ▼
Date of Birth (mm/dd/yyyy) *	[ ]
Business Relationship to Enrolling Provider *	-- Select One -- ▼
Familial Relationship to Enrolling Provider *	-- Select One -- ▼

[Add Managing Relationship]

Managing Relationships

First Name	Middle Name	Last Name	Suffix	SSN	Date of Birth	Business Relationship	Other Explanation	Familial Relationship	Delete
Provider Contact Person		Provider Contact Person		***-**-1111	02/13/2000	Officer		Spouse	

Ownership, Associations & Affiliations

Ownership & Associations

Disclose any ownership and association information.

Ownership & Associations

Required fields are marked with an asterisk (*).

Select the appropriate Ownership Type *   [Individual ▾]

Do you have one or more Shareholders/Partners with 5% or more ownership? *

◉ Yes   ○ No

Shareholders and Partners

Please provide information on all shareholders / partners who have 5% or more shares / ownership.

This Shareholder / Partner is *   ○ Individual   ○ Business

Existing Shareholder or Partner for Business

Business Legal Name	Provider Tax Identification Number (TIN) or Employer Identification Number (EIN)	% Ownership	Delete

Existing Shareholder or Partner for Individual

Last Name	First Name	Middle Name	Suffix	Date of Birth	SSN	% Ownership	Familial Relationship	Delete

Affiliation Information

Disclose any affiliation information.

Affiliation Information

Required fields are marked with an asterisk (*).

Note : This section will affiliate an individual provider with an organization/group. This affiliation will not reassign benefits. Only the provider may reassign benefits to the organization/group.

Do you wish to link or affiliate with an organization or group? *
⦿ Yes ◯ No

Affiliated Provider Information

Provide the NPI, SCDHHS # (Medicaid Provider Number), and the Name of the Organization or Group for each affiliation.In order to affiliate to an organization or a group, the organization must be enrolled.

Note: When the organization or group you are affiliating is enrolled with SCDHHS using one NPI across multiple locations, you must enter the assigned SCDHHS # (Medicaid Provider Number) of the specific location you wish to affiliate. If you do not know the SCDHHS # of the specific location, contact the Provider Services Center at (888) 289-0709, option 4.

SC DHHS #:	
National Provider Identifier (NPI) *:	
Organization Name *:	

[Add Affiliation]

Existing Affiliation for Business

SC DHHS #	NPI	Provider Name	Delete
123123123			⊖

Sanctions, Trading Partners, W-9 & EFT

Sanctions

Disclose any exclusions or sanctions you may be subject to.

Trading Partner Agreement

Enter your trading partnership information.

Provider Contact Information

Provider Contact First Name *:	
Provider Contact Last Name *:	
Provider Contact Middle Name:	
Provider Contact Suffix	-- Select One -- ▾
Telephone Number *:		Telephone Number Extension:	
Alternate Telephone Number:		Alternate Telephone Number Extension:	
Email Address *:	
Re-enter Email Address *:	
Fax Number:	

Preference Aggregation of Remittance Data (e.g., Account Number Linkage to Provider Identifier) *:
○ Provider Tax Identification Number (TIN)   ○ National Provider Identifier (NPI)   ○ Social Security Number (SSN)

Claims Submission/Retrieval Information

Are you using a clearinghouse, billing agent, or vendor to submit your claims? *:   ○ Yes   ○ No

South Carolina Medicaid Web-Based Claims Submission Tool

Select One *:   ○ Requesting Access   ○ No Access Needed   ○ Link To Existing IDs

Note: Approved providers are able to access their remittance advices online via the South Carolina Medicaid Web Tool.

TPA Authorization Agreement

☐ I have read, understand and agree with the conditions set forth in the South Carolina Trading Partner Agreement for Electronic Claims and Related transactions.

Electronic Signature of Person Submitting
Enrollment: Submission Date: 06/16/2015

W-9 Information

Enter your W-9 information.

W-9 Request for Taxpayer Identification Number and Certification

Required fields are marked with an asterisk (*).

Provider Tax Classification

Name (should match the name on your income tax return):

Business Name:

Select the applicable federal tax classification * :

- ○ Individual/Sole Proprieter
- ○ C Corporation
- ○ S Corporation
- ○ Partnership
- ○ Trust/Estate
- ○ Limited Liability Company
- ○ Other

Address Information

Address Line 1		Address Line 2	
City		State/Province	
Zip Code/Postal Code (Zip * + 4)			
List account number(s) here (optional):			
Requestor's name and address	SC Health & Human Services, P.O. Box 8809 Columbia, SC 29202-8809		

Part I: Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on the Name line to avoid backup withholding. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see **How to get a TIN on page 3**

Note. If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.

SSN

Part II: Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and

2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and

3. I am a U.S. citizen or other U.S. person (defined below).

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions on page 4.

Signature of U.S. Person: *:   ☐ Electronically signed by *

Date *:   06/16/2015

Electronic Funds Transfer (EFT) Authorization Agreement

Enter your EFT information.

South Carolina Department of Health and Human Services Electronic Funds Transfer (EFT) Authorization Agreement

Required fields are marked with an asterisk (*).

Provider Information

Provider Name:		Doing Business As Name (DBA):	
Street:			
City:	State/Province:	Zip Code/Postal Code:	
Social Security Number (SSN):	National Provider Identifier (NPI):		

Provider Contact Information

(Contact Name may be different than enrolling provider or Contact Person listed in the application)

Provider Contact First Name *

Provider Contact Last Name *

Provider Contact Middle Name

Provider Contact Suffix   -- Select One --

Telephone Number *   Telephone Number Extension

Email Address *

Re-enter Email Address *

Financial Institution Information

Financial Institution Name * [   ]

Street * [   ]

Street Line 2 [   ]

City * [   ]

State/Province * [-- Select One -- ▼]

Zip Code/Postal Code * [   ]

Financial Institution Routing Number * [   ]

Type of Account at Financial Institution *:   ○ Checking   ○ Savings

Providers Account Number with Financial Institution * [   ]

Account Number Linkage to Provider Identifier *:   ○ Provider Tax Identification Number (TIN)   ● National Provider Identifier (NPI)   ○ Social Security Number (SSN)

National Provider Identifier (NPI) * [   ]

Note: When changes to the information populated in either the NPI or TIN/EIN fields in this section are needed, please return to the TPA page of this application and make the necessary changes in the Preference Aggregation of Remittance Advice

Reason for Submission

☐ New Enrollment *

I (we) hereby authorize the Department of Health and Human Services to initiate credit entries and to initiate, if necessary, debit entries for any credit entries in error to my account indicated above and the financial institution named above, to credit and/or debit the same to such account. These credit entries will pertain only to the Department of Health and Human Services payment obligations resulting from Medicaid services rendered by the provider.

I (we) understand that credit entries to the account of the above named payee are done with the understanding that payment will be from federal and/or state funds and that any false claims, statements or documents or concealments of a material fact, may be prosecuted under applicable federal or state laws

I (we) certify that the information shown is correct. I (we) agree to provide thirty (30) days written notice to the SC Department of Health and Human Services Medicaid Provider P.O. Box 8809, Columbia, SC 29202-8809 prior to revoking or revising this authorization.

EFT Authorization Agreement

All EFT requests are subject to a fifteen (15) day pre-certification period in which all accounts are verified by the qualifying financial institution before any Medicaid direct deposits are made.

☐ I have read, understand, and agree with the conditions set forth in the SCDHHS Electronic Funds Transfer (EFT) Authorization Agreement and all related transactions.

Electronic Signature of Person Submitting Enrollment: _____   Submission Date *: [06/16/2015]

Special Instructions: For questions regarding the status of your EFT enrollment, please contact the Provider Service Center at 1-888-289-0709. Please refer to the Electronic Funds Transfer (EFT) section of the Provider Enrollment manual found on the SCDHHS Provider web page for instructions on how to complete updates to your EFT information.

Effective January 1, 2014, providers have the capability to link their EFT payment transaction with their electronic remittance advice (ERA) via a matching EFT Reassociation Trace Number. This trace number will automatically be included in your SCDHHS electronic remittance advice. In order for this matching reassociation trace number to appear in your EFT notification, you must contact your financial institution and request the addition of this information. Any questions regarding this matching reassociation trace number and your ERA can be directed to your Provider Service Center at 1-888-289-0709.

Terms & Conditions/Review & Submit

Terms and Conditions

Agree to the terms and conditions.

Participation and Payment Agreement

AS A CONDITION OF PARTICIPATION AND PAYMENT, I UNDERSTAND AND AGREE;

That this agreement shall not be assigned or transferred.

That upon acceptance of this agree
claims.

That services shall be provided to
Discrimination Act of 1975 and any

Participation and Payment Attestation

When your enrollment requires the execution of a contract, SCDHHS will contact you prior to enrollment approval.

☐ I certify that I have read the conditions of participation and payment and that I understand and agree to the conditions of the
information I have furnished is true, accurate, complete, and current as of the date of this attestation. I have not herein knowingl
any material fact that would constitute a false, fictitious or fraudulent statement or representation and that I will report any chan
that I will obtain authorization from each Medicaid patient to release to South Carolina Department of Health and Human Service
for processing Medicaid claims.

Furthermore, by checking this box, I consent to criminal history background checks including fingerprinting when required to d
screening based on risk of fraud, waste or abuse as determined for that category of provider.

Date: 06/16/2015

Participation and Payment Agreement Electronic Signature

☐ I understand that by checking the electronic signature box of this Participation and Payment Agreement included with the p
signed contract with South Carolina Department of Health and Human Services.

Electronically Signed By: [redacted]   **Date:** 06/16/2015

South Carolina Trading Partner Agreement For Electronic Claims And Related Transactions

I. General

The Trading Partner identified on the SC Medicaid Trading Partner Agreement Enrollment Form agrees to the terms and conditions of this

II. Purpose

A. This TPA outlines the requirements for the electronic transfer of protected health information (PHI) between the Trading Partner and
Human Services (SC

Trading Partner Agreement Attestation

☐ I have read, understand, and agree with the conditions set forth in the SCDHHS Trading Partner Agreement for Electro

Trading Partner Agreement Electronic Signature

☐ I understand that by checking the electronic signature box of this Trading Partner Agreement, included with this provi
contract with the South Carolina Department of Health and Human Services.

Electronically Signed By [redacted]   **Date:** 06/16/2015

Provider Enrollment Application Electronic Signature

☐ I understand that by checking the electronic signature box on the Terms and Cond
provider enrollment application constitutes a signed contract with South Carolina Dep

Date: 06/16/2015

Electronically Signed By [redacted]

Review and Submit

Review your application, and then click *Submit the Application*.

REVIEW AND SUBMIT

To review or print your application in Adobe PDF format, select the Download Application button. To make changes to information entered, select Cancel to return to the navigation page. If you have successfully completed all required information for your provider enrollment application and are satisfied the information is complete and accurate, submit your application by clicking the Submit the Application button.

Once you have submitted your application, you will not be able to retrieve the application via the Reference ID or reprint the submitted application.

If you have not already done so, please record you reference number. Please select Submit the Application to complete your enrollment.

Reference ID #

Download the Application to keep for your records. You will be downloading a PDF document. If you do not have Adobe Reader installed on your computer to view the PDF, download the latest version from Adobe by clicking on the Get Adobe Reader icon and following the directions on the Adobe web site.

Get ADOBE READER

| Back | Download Application | Submit the Application | Cancel |

Submission Complete

Click *Exit* once your enrollment has been successfully submitted.

Submission Complete

Your enrollment has been successfully submitted.
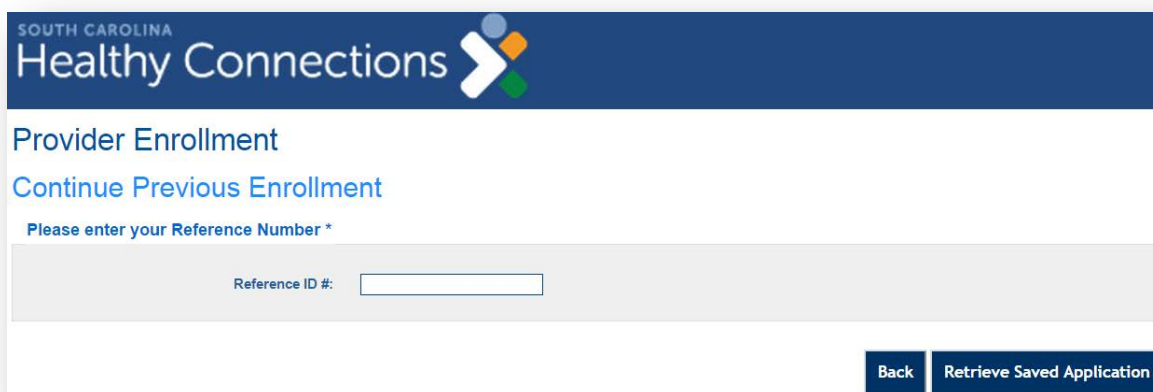
Exit

Other Enrollment Types

This addendum builds on the enrollment procedures shown above.

Continue a Previous Enrollment

Click *Continue an Existing Enrollment*.

Enter you Reference ID # and select *Retrieve Application*.

Note: You will not be able to retrieve an application that has already been submitted.

Add a Location

Click *Begin a New Enrollment*.

| Begin a New Enrollment | Continue an Existing Enrollment | Enrollment Revalidation | Change Request |

Select *Add a Location*, complete the required information, and receive your Reference ID #.

Provider Services Menu

Required fields are marked with an asterisk (*).

Please choose the option that best describes your intent: *

○ New Enrollment   ● Add a Location

Are you a Pharmacy Provider? *   ○ Yes   ○ No

Medicaid Service Area (MSA) Determination:

Please choose the State of your Primary Practice Location *:   SC ▼

The Medicaid Service Area determination is In-State.

Add a Location -
Information

Medicare and Other State Medicaid/CHIP Information

Are you enrolled in Medicare? *:   ○ Yes   ○ No

Are you enrolled in another state's Medicaid/CHIP? *:   ○ Yes   ○ No

Application Fee Notice

An application fee is applicable to all providers enrolling as an organization with an Employee Identification Number (EIN). The application fee must be collected prior to executing an initial, reactivation, or revalidation provider enrollment agreement or when enrolling an additional practice location.

Unless you meet the exception criteria below, you may make a payment by electronic check, credit card or by debit from your checking or savings account.   Please Note: Paper checks are not accepted. Once the application fee payment has been made, proceed with completing the enrollment application.
To make a payment, click this link: https://ssl.sc.gov/Checkout/DHHS/

The exceptions to this statement are:

- For new South Carolina provider enrollments, the application fee has been previously paid when enrolling in the Medicare or other states Medicaid or CHIP program.
- A hardship request has been approved.

The Hardship Waiver Exception Request form is located in the Forms Section on the SC Healthy Connections Medicaid website. Please Note: The Hardship Waiver Exception Request form and supporting documentation must be completed and submitted to Provider Enrollment after the submission of the enrollment application.
To access the Hardship Waiver Exception Request form, click this link: https://www.scdhhs.gov/provider/

Organization Details

Please enter Provider Name - as shown on income tax return.

Provider Name *

Provider Tax Identification Number (TIN) or Employer Identification Number (EIN) *

National Provider Identifier (NPI) *

Month of Fiscal Year End *   -- Select One -- ▾

Contact Email Address *

Re-enter Contact Email Address *

Do you operate under a trade or company name, e.g. Acme Healthcare Services doing business as name (DBA) Community Family Practices? *   ◉ Yes   ○ No

Doing Business As Name (DBA) Information

Doing Business As Name (DBA) *

Years doing business under this name *

Have you used a different Doing Business As Name (DBA)?*   ○ Yes   ◉ No

Reference ID:

You have successfully completed the basic information of the enrollment application.

Please print this Reference ID page for your records. You will need this number to complete and retrieve your saved application. Please complete this application within 30 days for submission to the State. If not completed within 30 days the incomplete application will be deleted.

The Reference ID will be e-mailed to the **"Contact email address"** listed on the providers Organizational Information page.

Reference ID #:

Revalidation

Click *Enrollment Revalidation*.

Type in the corresponding information from the revalidation letter you received.

Select *Retrieve Current Enrollment Application.*

Then verify your information as you follow the standard enrollment process.