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www.scdhhs.gov

Date: \_\_\_\_\_

Provider Name  
Address  
City, State, Zip code

Revalidation # \_\_\_\_\_  
Medicaid Provider # \_\_\_\_\_  
NPI # \_\_\_\_\_

Dear Medicaid Provider:

The April 2, 2018 alert, informed you that your enrollment information must be revalidated. This letter serves as your official revalidation notification.

**Revalidate**

Please refer to <https://providerservices.scdhhs.gov/ProviderEnrollmentWeb/> to access the enrollment application. Select the **enrollment revalidation** button and enter the combination of numbers listed above to begin the enrollment process. You have 30 days from the date of this notification to complete and submit your application. Failure to do so will result in termination from the South Carolina Healthy Connections Medicaid program.

**Discontinue Enrollment**

If you **DO NOT** wish to continue your enrollment, you must authorize the **termination** of your Medicaid Provider number. It is **required** that you attest to the statement below and return this letter within five days via fax (803) 870-9022 or mail to Medicaid Provider Enrollment, PO Box 8809, Columbia, SC 29202-8809.

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I attest that {auto fill provider name}, wishes to terminate enrollment with South Carolina Healthy Connections Medicaid for {auto fill Medicaid Provider #}. If you choose to participate with SC Healthy Connections Medicaid in the future, you will be required to complete and submit a new enrollment application.

Print Name: \_\_\_\_\_ Signature: \_\_\_\_\_

Date: \_\_\_\_\_ Relationship to provider: \_\_\_\_\_

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If you have any questions, please visit <https://msp.scdhhs.gov/revalidation/>. Thank you for your continued support of the South Carolina Healthy Connections Medicaid program.

Sincerely,

Medicaid Provider Enrollment