SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

Henry McMaster GOVERNOR
Robert M. Kerr DIRECTOR
P.O. Box 8206 > Columbia, SC 29202
www.scdhhs.gov

Date:

Provider Name
Address
City, State, Zip code

Revalidation #
Medicaid Provider #
NPI #

Dear Medicaid Provider:

The South Carolina Department of Health and Human Services' (SCDHHS) is required by federal regulations (42 CFR §455.414) to complete revalidation of enrollment for all providers enrolled in the Healthy Connections Medicaid program, regardless of provider type. This letter serves as your official revalidation notification. Your two options for revalidation completion are below.

Revalidate
Please visit the SCDHHS website at www.scdhhs.gov/pe-revalidate. Here you will enter the revalidation, Medicaid provider and National Provider Identifier (NPI) numbers listed at the top of this letter. You have 30 days from the date of this letter to complete and submit the online portion of your revalidation application. Failure to do so will result in termination from the South Carolina Healthy Connections Medicaid program.

Because you are enrolled as a provider type designated as high risk, you are required to complete a fingerprint-based criminal history background screening. This may take longer than the 30-day deadline. As long as you submit a copy of your fingerprinting appointment confirmation along with other documents requested of you, you will not be terminated. Additionally, a site visit will be scheduled which may also take longer than the 30-day deadline.

Or

Discontinue Enrollment
If you decide to no longer participate as a South Carolina Healthy Connections Medicaid provider, you must request a voluntary **termination** of your Medicaid Provider number. Confirm your decision by signing the statement below and returning this letter within 10 days via fax at (803) 870-9022 or by mail to Medicaid Provider Enrollment, P.O. Box 8809, Columbia, SC 29202-8809.

I confirm that {auto fill provider name} chooses to voluntarily terminate participation as a provider with South Carolina Healthy Connections Medicaid for {auto fill Medicaid Provider #}. I acknowledge that should I choose to participate with South Carolina Healthy Connections Medicaid in the future, I will be required to complete and submit a new enrollment application.

Date: _____ Relationship to Provider: _____
Print Name: _____ Signature: _____

If you have any questions, please visit www.scdhhs.gov/providers/revalidation.

Thank you for your continued support of the South Carolina Healthy Connections Medicaid program.

Sincerely,

Medicaid Provider Enrollment