



**Select
Health**

Facility/Vendor Panel & Credentialing Request

Thank you for your interest in Select Health. To expedite your facility/vendor panel request (allow up to 60 days for processing), complete this form and return it to **provider.development@selecthealth.org**. Incomplete submissions may result in delays.

Provider & Business Information

Today's Date:

NPI: TIN:

Provider Name:

Provider DBA:

Primary Clinic Address:

City: State: Zip:

Payment Address:

City: State: Zip:

Contact Name:

Phone: Email:

Service Areas (States/Counties):

Hours of Operation: Years in Business:

Accreditations:

Additional Locations (Attach additional sheets if needed)

Address	City	ST	Zip	Phone	Fax

Business Statements

What value will you bring to Select Health and its members?

How do you plan to support affordability for members and the health plan?

What makes your services stand out from other similar providers?

Services Information

Services offered:

Are the services you are applying for already offered in your area? ☐ Yes ☐ No

If "yes," please identify the services already offered in your area.

Applicable Codes

(Attach additional sheets if needed)

Code(s)	Description	Requested Rate (not guaranteed)

Requested Networks

State	Commercial	Medicare Advantage	Medicaid
UT	Select Health Signature	Select Health Medicare MA#: <input type="text"/>	Select Health Community Care Medicaid#: <input type="text"/>
	Select Health Med		
	Select Health Share		
	Select Health Care		
	Select Health Value		
ID	Select Health Med	SH Medicare - MA# <input type="text"/>	
NV	Select Health Med	Select Health Medicare MA#: <input type="text"/>	
	Select Health Value		
CO	Select Health Med	Select Health Medicare MA#: <input type="text"/>	
	Select Health Value		

Attachments Included (check all appropriate boxes)

☐	CLIA (Hospitals, SNFs, or Labs)	☐	W-9
☐	State Business License(s)	☐	Liability Insurance Certificate
☐	Accreditation Certificate/Certification Information <i>If not accredited, provide applicable Annual State Surveys</i>	☐	Drug Enforcement Administration (DEA) Certificate
☐	Medicare certification or letter from CMS - CMS MA#: <input type="text"/>		
☐	Medicaid certification or letter from State - State Medicaid #: <input type="text"/>		

Email completed form to: **chris.engh@selecthealth.org**

DISCLAIMER: This application is not a guarantee of a paneling decision or network inclusion. If selected, additional credentialing information will be requested during the contracting process. Please do not attach credentialing documentation to this request.