Select Health Facility/Vendor Panel Request

Today's Date _____

Thank you for your interest in joining Select Health networks. To expedite your request, please complete all fields. Once the completed form has been returned to us, the Select Health panel will evaluate the needs of our members to make our determination. Incomplete fields may result in a delayed decision. Please allow 55 days for review.

Provider Information

NPI _____ TIN _____

Provider Name _____

Primary physical address _____

City _____ State _____ Zip _____

Additional address _____

City _____ State _____ Zip _____

Contact Name _____

Contact Area Code/Phone # _____

Contact Email _____

Service Areas (States, Counties) _____

Additional Location Information (add separate sheeet if needed)

Address	State

Business Information

Accreditations _____ # Years in Business _____

Explain the value you bring to Select Health and its members.

How do you plan to support member/health plan affordability?

What makes your services stand out from other similar provider types?

Business Email _____ Business Phone _____

Payment Address _____

Hours of Operation _____

Select Health

Select Health Facility/Vendor Panel Request, Continued

Service Information

Service(s) offered

Are services you are applying for already offered in your services area? ◯ **Yes** ◯ **No**

If "yes," please identify which services.

Applicable Codes (attached additional sheets if needed)		
Code(s)	**Description**	**Requested Rate (not a guaranteed rate)**

Requested Networks

State	Commercial Networks	Medicare (Advantage) Networks	Medicaid Network
UT	☐ Select Health Signature ☐ Select Health Med ☐ Select Health Share ☐ Select Health Care ☐ Select Health Value	☐ Select Health Medicare	☐ Select Health Community Care
ID	☐ Select Health Med	☐ Select Health Medicare	
NV	☐ Select Health Value	☐ Select Health Medicare	
CO	☐ Select Health Value	☐ Select Health Medicare	

Medicare #:_____Medicaid # (Utah only): _____

Submittal Information

Please complete and return this form to the Provider Development department at

provider.development@selecthealth.org.

DISCLAIMER: This application is not a guarantee of paneling decision; it is simply a tool for collecting pertinent information. If selected, additional credentialing information will be requested during the contracting process. Please do not attach credentialing documentation to this request.

Select Health