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Date: Month Day, Year

PROVIDER  
PROVIDER MAILING ADDRESS

Revalidation #            XXXXXXX  
Medicaid Provider #    XXXXXX  
NPI #                        XXXXXXXX

Dear Medicaid Provider:

In the bulletin dated April 20, 2015, you were informed your enrollment information must be revalidated. This letter serves as your official revalidation notification. The revalidation, Medicaid provider and National Provider Identifier (NPI) numbers listed above will be needed to start the enrollment process. Please refer to <https://providerservices.scdhhs.gov/ProviderEnrollmentWeb/> to access the enrollment application. Select the revalidate enrollment button to begin. You will have 30 days from the date of this notification to complete and submit your application. Failure to complete and submit application as requested will result in termination from the South Carolina Healthy Connections Medicaid program.

The enrollment application fee is **ONLY** applicable to providers that CMS has identified as institutional providers. The application fee must be collected before a revalidation provider enrollment agreement is submitted unless the provider is already enrolled in Medicare, enrolled in another state's Medicaid or CHIP program or submitted and received approval for a Hardship Waiver request. Payment may be made by debit, credit or e-check. Paper checks **will not** be accepted. Please refer to <https://ssl.sc.gov/Checkout/DHHS/> for the online application fee payment. South Carolina Healthy Connections Medicaid recognizes and enrolls the following institutional providers:

Ambulatory Surgery Centers, Community Mental Health Centers; Comprehensive Outpatient Rehabilitation Facilities; Durable Medical Equipment, End State Renal Disease Facilities; Federally Qualified Health Centers; Home Health Agencies; Hospices; Hospitals, Acute Inpatient Facilities, Inpatient Psychiatric Facilities, Inpatient Rehabilitation Facilities, Independent Clinical Laboratories; Skilled Nursing Facilities and Rural Health Clinics.

If you choose not to continue your participation, please complete the section below and return it within five days via mail (Medicaid Provider Enrollment, PO Box 8809, Columbia, SC 29202-8809) or fax (803) 870-9022.

No, I do not wish to continue my participation.

Print Name and Title: \_\_\_\_\_

Provider's Signature/Date: \_\_\_\_\_

If you have any questions, please visit <https://msp.scdhhs.gov/revalidation/> or contact the Provider Service Center (PSC) at (888) 289-0709, option 4 for more information on the revalidation process.

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

Sincerely,

Medicaid Provider Enrollment