Healthcare Provider Empanelment Registration Form

SELECTION CRITERIA FOR SELCARE PANEL OF HEALTHCARE PROVIDER

1. Healthcare Provider must be registered with Malaysia Medical Council (MMC) and has a valid Annual Practicing Certificate (APC).

2. Facilities available e.g. : Internet, PC and Telephone.

3. Location.

4. Healthcare Provider Fees charged must adhere to Malaysian Medical Association (MMA)'s terms & conditions.

5. Business Hours.

6. Healthcare Provider Services.

7. For GP clinic applications,
   a) Your GP clinic will be automatically empanelled under Selcare Third Party Administrator program.

   b) Your application will be empanelled under the State Programs handled by Selcare Management subject to each of State Government's discretion. Please tick (X) your GP clinic's location:-
   7.1 Perak (Perak Sejahtera program) ☐ 7.3 Terengganu (Kad Sejahtera Terengganu program) ☐
   7.2 Selangor (Iltizam Selangor Sihat program) ☐ 7.4 Others (Please specify) : _____ ☐

   c) Your GP clinic will be required to send all laboratory tests to Selcare Diagnostics for processing and analysis after successful empanelment.

If Healthcare Provider meets selection criteria, a letter of offer will be prepared upon receiving letter of acceptance from Healthcare Provider, an agreement will be forwarded to Healthcare Provider to be signed by both parties. A copy will be given to panel Healthcare Provider.

HEALTHCARE PROVIDER REGISTRATION CHECKLIST

No.	Documents	Checklist
1	Panel of Healthcare Provider: Letter of Invitation	☐
2	Panel of Healthcare Provider: Details Form	☐
3	Annual Practicing Certificate (APC)	☐
4	Malaysian Medical Certificates (MMC)	☐
5	Private Healthcare Facilities and Services Act 1998 (GP Clinic : Form B/Form F, Dental Clinic : Form C, Hospital : Form G)	☐
6	Healthcare Provider Summary of Charges	☐
7	Company Registration Suruhanjaya Syarikat Malaysia for "Sdn. Bhd." company only (Form 24 and Form 49)	☐
8	Bank Account Statement of Payee	☐

Note: Please submit the completed application to our dedicated email at **provider@selcare.com**. Any enquiries regarding this application to call our Customer Care at 1-800-22-6600.

FOR OFFICE USE ONLY

Approved / Rejected by: _____ Signature _____

Reason Rejected _____ Date __ __ / __ __ / __ __ __ __

Panel of Healthcare Provider - Letter of Invitation (LOI)

To	**SELCARE Management Sdn Bhd**
Tel. No.	**1-800-22-6600**
Fax No.	**03-5525 6900**
Attention	**Provider Management Department**

REPLY OF INVITATION / APPLICATION TO JOIN SELCARE A PANEL GP CLINIC

☐ Hospital ☐ General Practitioner ☐ Dental ☐ Others _____

Please tick either one.

☐ **YES.** I would like to be a panel service provider of SELCARE Management Sdn. Bhd. I am pleased to forward to you a quotation of our charges. Please forward to me a copy of the Letter of Appointment of which I shall return to SELCARE Management Sdn. Bhd. signing.

☐ **NO**. I am not interested in being a panel service provider of SELCARE Management Sdn. Bhd.

Healthcare Provider Name			
Doctor-in-charge Name		Staff-in-charge Name	
MyKad / I.C No.		MyKad / I.C No.	
Membership / Valid Practising No.		Membership / Valid Practising No.	
Contact No.		Contact No.	

Please tick where appropriate

Do you have internet connection for your PC?	☐ Yes	☐ No
Where do you station your computer terminal?	☐ Registration Counter	☐ Doctor's Room
Your computer system network?	☐ Stand Alone	☐ Sharing / Networking

Panel of Healthcare Provider - Details Form

To	**SELCARE Management Sdn. Bhd.**
Tel. No.	**1-800-22-6600**
Fax No.	**03-5525 6900**
Attention	**Provider Management Department**

Dewan Undangan Negeri/ State Constituency	
Healthcare Provider Name*	
Party to be Named in Service Agreement	
	***(Healthcare Provider Name / Company Name – please provide us "Form 49" if registered as "Sdn. Bhd.")**
Group of (if any)	
Address	
Postcode	City / Town
Healthcare Provider Coordinates	Latitude / Longitude
Healthcare Provider Hours	☐ 24 Hours a day ☐ Others. Please specify below: ☐ i) Monday to Friday. Time ☐ ii) Saturday. Time ☐ iii) Sunday. Time
Tel. No.	Mobile No.
Email	
Bank Details	Payee Name
	Payee Bank
	Payee Bank Account No.
	Payee NRIC (if individual)
	Payee Business Registration No. (BRN) (if sole Proprietor / Partnership)
	Payee Company No. (if Company)

Important note: Please attach the latest copy of "Perakuan Amalan Tahunan" (Annual Practicing Certificate).

Signature	Healthcare Provider Stamp
Name	
Date	/ /

Panel of Healthcare Provider - Summary of Charges

No.	Type of treatment	Rate / Charges (RM)	Internal Use
1	Consultation only		
2	Consultation and Medication (General)		
3	Consultation + Medication + Injection		
4	Minor Surgery (procedure) _____ _____ _____ _____ _____ _____ _____		
5	X-ray		
6	Simple investigation Blood glucose test Urine test (using test strip) ECG Ultrasound examinantion Pap Smear		
7	Pre-employment Medical Check-up **(please list out all the tests)** _____ _____ _____ _____ _____ _____		

Prepared by

Name _____

Designation _____

Healthcare Provider Stamp