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, Fax Machine, 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.

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	Private Healthcare Facilities and Services Act 1998 (Form B / Form F)	☐
5	Healthcare Provider Summary of Charges	☐
6	Panel of Healthcare Provider : Approval Form	☐
7	Company Registration Suruhanjaya Syarikat Malaysia, Form 24 and Form 49 (for "Sdn. Bhd." only)	☐

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

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 Healthcare Provider ☐ Dental ☐ Dialysis ☐ 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	
Staff-in-charge	
Healthcare Provider Stamp	
Date	/ /

Please tick where appropriate

Do you have internet connection for your PC? ☐ Yes ☐ No

Do you have a fax machine at your Healthcare Provider? ☐ Yes Fax No. _____ ☐ 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**

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
  - ☐ Monday to Friday. Time
  - ☐ Saturday. Time
  - ☐ Sunday. Time

Tel. No. | Fax 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

Name

Date ☐☐/☐☐/☐☐☐☐

Healthcare Provider Stamp

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

Panel of Healthcare Provider -Approval Form (For Office Use Only)

Healthcare Provider Name			
Address		Business Hour	
		Email	
		Person-in-charge	
Postcode		City / Town	
Tel. No.		Fax No.	
Healthcare Provider Code		User ID	

Application Checklist

- ☐ Letter of Invitation — Date Sent: ____ Date Received: ____
- ☐ Annual Practicing Certificate (APC) — Date-in-charge: ____ Duration Date: ____
- ☐ Acceptable Charge List (Summary of Charge). Please Refer Attached.
- ☐ Private Healthcare Facilities and Services Act 1998 (Form B / Form F)
- ☐ Company Registration SSM (Form 24 and Form 49)
- ☐ Smart Terminal — ☐ Yes — Date Sent: ____ Date Received: ____
  ☐ No

Reason for Recruitment

- ☐ Requested by: ____
- ☐ Requested by Member

Type of Provider

- ☐ Hospital
- ☐ Dental
- ☐ GP Healthcare Provider
- ☐ Maternity
- ☐ Specialist Healthcare Provider

Criteria of Recruitment

Location: ____

Type of Services: ☐ Minor Surgery ☐ Primary Care ☐ Pre-Employment Checkup

Prepared by	**Approved by** (Provider Management)	**Approved by**
Name:	Name:	Name:
Date: / /	Date: / /	Date: / /

Approved by (Medical)	**Notification to ED / MD Office**	**Request Status**
Name:	Name:	☐ Accept ☐ Reject
Date: / /	Date: / /	If Reject, Reason: