

## 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) <input type="checkbox"/>	7.3 Terengganu (Kad Sejahtera Terengganu program) <input type="checkbox"/>
7.2 Selangor (Iltizam Selangor Sihat program) <input type="checkbox"/>	7.4 Others (Please specify) : _____ <input type="checkbox"/>
  - 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	<input type="checkbox"/>
2	Panel of Healthcare Provider: Details Form	<input type="checkbox"/>
3	Annual Practicing Certificate (APC)	<input type="checkbox"/>
4	Malaysian Medical Certificates (MMC)	<input type="checkbox"/>
5	Private Healthcare Facilities and Services Act 1998 (GP Clinic : Form B/Form F, Dental Clinic : Form C, Hospital : Form G)	<input type="checkbox"/>
6	Healthcare Provider Summary of Charges	<input type="checkbox"/>
7	Company Registration Suruhanjaya Syarikat Malaysia for "Sdn. Bhd." company only (Form 24 and Form 49)	<input type="checkbox"/>
8	Bank Account Statement of Payee	<input type="checkbox"/>

**Note:** Please submit the completed application to our dedicated email at [provider@selcare.com](mailto: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	<input type="text"/>		
Doctor-in-charge Name	<input type="text"/>	Staff-in-charge Name	<input type="text"/>
MyKad / I.C No.	<input type="text"/>	MyKad / I.C No.	<input type="text"/>
Membership / Valid Practising No.	<input type="text"/>	Membership / Valid Practising No.	<input type="text"/>
Contact No.	<input type="text"/>	Contact No.	<input type="text"/>

#### 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	<b>SEL CARE Management Sdn. Bhd.</b>
Tel. No.	<b>1-800-22-6600</b>
Fax No.	<b>03-5525 6900</b>
Attention	<b>Provider Management Department</b>

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	
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Healthcare Provider Hours	<input type="checkbox"/> 24 Hours a day	<input type="checkbox"/> Others. Please specify below:	
		<input type="checkbox"/> i) Monday to Friday. Time	
		<input type="checkbox"/> ii) Saturday. Time	
		<input type="checkbox"/> iii) Sunday. Time	

Tel. No.		Mobile No.	
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Email	
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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	
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## 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) <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>		
5	X-ray		
6	Simple investigation <input type="text"/> Blood glucose test <input type="text"/> Urine test (using test strip) <input type="text"/> ECG <input type="text"/> Ultrasound examination <input type="text"/> Pap Smear		
7	Pre-employment Medical Check-up <b>(please list out all the tests)</b> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>		

### Prepared by

Name

Designation

Healthcare Provider Stamp