Health care professional — special needs survey form

To complete our credentialing process, please fill out this form. It helps us accurately record your training, experience and readiness to care for members with special needs.
Please complete all blank fields.

Health care professional name:	Specialty:
National Provider Identifier (NPI) number:	County:
Email:	Phone:

1. Are you accepting members with special needs? (Check all that apply)

	Ages					
	0-5	**6-13**	**14-17**	**18-21**	**21-65**	**65 & older**
☐ I am a primary care provider (PCP) accepting members with special needs	☐	☐	☐	☐	☐	☐
☐ I am a specialist accepting members with special needs	☐	☐	☐	☐	☐	☐
☐ I am a PCP/specialist and not accepting members with special needs						

2. If accepting members with special needs, please provide the following special needs training/experience and certifications. Attach a copy of any documentation, if applicable.

Training/experience	Answer each question yes or no		If you answered yes, please list your qualifications, including formal training and/or experience, to treat adults/children with special needs
Aged, elderly 65 and older	☐ Yes	☐ No	
Cognitive impairment	☐ Yes	☐ No	
Family planning	☐ Yes	☐ No	
Foster care or government agency care	☐ Yes	☐ No	
Genetic inherited or congenital disorder	☐ Yes	☐ No	
Gender affirming	☐ Yes	☐ No	
Hearing impairment	☐ Yes	☐ No	
HIV/AIDS	☐ Yes	☐ No	
Neurodevelopment (neurodiversity) disabilities	☐ Yes	☐ No	

2. If accepting members with special needs, please provide the following special needs training/experience and certifications. Attach a copy of any documentation, if applicable. (cont.)

Training/experience	Answer each question yes or no		If you answered Yes, please list your qualifications, including formal training and/or experience, to treat adults/children with special needs:
Nonambulatory	☐ Yes	☐ No	
Speech impairment	☐ Yes	☐ No	
Spinal cord/brain injury	☐ Yes	☐ No	
Substance use disorder, including alcohol	☐ Yes	☐ No	
Transgender care	☐ Yes	☐ No	
Traumatic brain injury	☐ Yes	☐ No	
Trauma informed care, including sexual abuse	☐ Yes	☐ No	
Visual impairment	☐ Yes	☐ No	
Other chronic condition	☐ Yes	☐ No	

Attestation

Instructions – Please sign, date and return this form by email to **NatlCred_Outreach@uhc.com.**

I attest the information I provided on this form is accurate and complete.

Health care professional or authorized representative name:

Health care professional or authorized signature:

Title:	Date:

Questions?

Connect with us through chat 7 a.m.– 7 p.m. CT in the **UnitedHealthcare Provider Portal.**
For additional contact information, visit our **Contact us** page.

United Healthcare® Community Plan