

# Join our network request submission – Ancillary providers and centers

## Birthing center questionnaire

To join our network as a birthing center, complete this form and visit our [contact resources](#) to connect with us through chat for submission instructions.

Go to [UHCprovider.com/join](https://UHCprovider.com/join) > [Ancillary providers](#) for more details on joining our network, including required documentation and submission instructions.

Eligibility criteria <sup>1</sup>	
<b>Facility accreditation</b>	<ul style="list-style-type: none"> <li>• Facility must be accredited by the Commission for the Accreditation of Birth Centers (CABC) and such accreditation must be current and maintained<sup>2</sup></li> <li>• Facility uses the standards of the American Association of Birth Centers (AABC) to provide support, education and accreditation to developing and existing birth centers</li> </ul>
<b>Continuous Quality Improvement (CQI)</b>	<ul style="list-style-type: none"> <li>• There is a documented CQI program identifying (through data) opportunities for real time, measured improvement in areas of core competencies in all covered service categories</li> <li>• There are demonstrated ties between CQI findings and staff</li> </ul>
<b>Joint Operating Committee</b>	<ul style="list-style-type: none"> <li>• There are standard, quarterly meetings upon request with UnitedHealthcare staff to review data reports, quality issues and address any administration issues, subject to mutual agreement and applicable contract terms</li> </ul>
<b>Staffing credentials</b>	<ul style="list-style-type: none"> <li>• All professional staff are certified or licensed in their applicable specialty or have a level of certification, licensure, education and/or experience in accordance with state and federal laws</li> <li>• Certified nurse midwife, certified professional midwife (CNMW, CNM, CPM, LM or CM) who is duly certified, licensed and qualified under the laws of the jurisdiction in which covered services are provided, and such credentials must be current and maintained<sup>2</sup></li> </ul>
<b>National Provider Identifier (NPI) number and taxonomy code 261QB0400X</b>	<ul style="list-style-type: none"> <li>• Birthing centers are:               <ul style="list-style-type: none"> <li>- Contracted exclusively as freestanding facilities</li> <li>- Licensed and accredited independently from hospitals, operate under a freestanding facility model and maintain hospital transfer agreements for emergencies</li> </ul> </li> <li>• Hospital-based delivery units, hospital birth suites and professional-only practices are not considered birthing centers for contracting purposes</li> </ul>



### Eligibility criteria<sup>1</sup>

<b>National Provider Identifier (NPI) number and taxonomy code 261QB0400X (cont.)</b>	<ul style="list-style-type: none"> <li>• <b>Classification:</b> Clinic/center (ambulatory health care facility)</li> <li>• <b>Specialization:</b> Birthing</li> <li>• <b>Definition:</b> Freestanding facility providing prenatal, labor/delivery and postpartum care (non-hospital setting)</li> </ul> <p><b>Place of service = 25</b></p>
<b>Eligible for home birth</b>	<ul style="list-style-type: none"> <li>• Low-risk, uncomplicated pregnancy</li> <li>• Singleton, head-down fetus</li> </ul>
<b>Term (37–41 weeks)</b>	<ul style="list-style-type: none"> <li>• No maternal/fetal conditions requiring intervention</li> </ul>

### Tax ID number (TIN)

TIN	National Provider Identifier (NPI) number	Associated legal name	Legal DBAs affiliated with provider

**If additional space is needed, please submit a separate attachment.**

### Provider contact and billing information

Contact name:	Title:	
Contact email:	Phone number:	
Mailing address:		
City:	State:	ZIP:
Practice website:		
Billing address:		
City:	State:	ZIP:

## Service information

A sample claim form for each provider type you are applying for (e.g., birthing center ) is required to evaluate your application.

Are you currently contracted with any UnitedHealthcare plans?    Yes    No  
If yes, which?    UnitedHealthcare Community Plan    UnitedHealthcare commercial plans

List the applicable Medicaid IDs by state in which you do business.

List all organization and operational licenses your legal entity holds by state in which you do business.

A copy of the accreditation certificate that your entity holds must be included in your submission. Acceptable accreditation institutions are outlined on page 1.

If you're requesting a new contract, indicate which products and states you are seeking a contract for:<sup>3</sup>  
Commercial plan(s)    Community Plan(s)

**Update the names of these plans as indicated above.**

Itemize specific plans by state:

Describe the classes of trade for which you acquire medications with manufacturers or wholesalers:

Provide an itemized list of chronic or specialty pharmacy medical benefit medications that you wish to administer for UnitedHealthcare members, with corresponding HCPCS/CPT® codes and brand names:

## Absolute exclusions for home birth

Category	Conditions and/or medications not eligible for home birth
<b>Fetal/obstetric – Breech or non-head-down</b>	<ul style="list-style-type: none"> <li>• Multiple gestation (twins+)</li> <li>• Prior C-section</li> <li>• Chronic hypertension/preeclampsia</li> <li>• Heart disease/congenital cardiac defects</li> </ul>
<b>Pulmonary embolism</b>	<ul style="list-style-type: none"> <li>• Anemia</li> <li>• Maternal high-risk cardiovascular care</li> <li>• Pre-existing diabetes</li> <li>• Insulin-controlled gestational diabetes</li> </ul>
<b>Endocrine-managed maternity (specialty care)</b>	<ul style="list-style-type: none"> <li>• Preeclampsia/gestational hypertension</li> <li>• Placenta previa/abruption</li> <li>• Pre-term labor (&lt;37 weeks)</li> <li>• Post-term labor (&gt;41–42 weeks)</li> </ul>
<b>Risk for postpartum hemorrhage</b>	<ul style="list-style-type: none"> <li>• Congenital anomalies</li> <li>• Hematologic</li> <li>• Neutropenia</li> <li>• Fetal growth restriction (IUGR)</li> </ul>
<b>Abnormal fetal heart rate</b>	<ul style="list-style-type: none"> <li>• Asthma, if controlled</li> <li>• Hemophilia</li> <li>• Oncology – injectable</li> <li>• Thromboembolic/anticoagulation</li> </ul>
<b>Oxygen therapy</b>	<ul style="list-style-type: none"> <li>• Recent hospitalizations for an acute condition</li> <li>• Hepatitis C</li> <li>• Neonatal complications</li> <li>• Uveitis, uncontrolled</li> </ul>
<b>Inotropic*</b>	<ul style="list-style-type: none"> <li>• Cardiovascular/heart failure</li> <li>• HIV/AIDS</li> </ul>
<b>Chelation therapy*</b>	<ul style="list-style-type: none"> <li>• Cystic fibrosis</li> <li>• Immune globulin IVIG therapy</li> </ul>

\*These condition or medication categories would prevent home births.

## Attestation

I attest that information entered above is accurate and valid and that I have attestation authority. This attestation acknowledges willingness and capability of submitting claims according to the UnitedHealthcare **National Drug Codes** claim submission and inquiry procedures for NDC billing units/ppoONE billing policy. UnitedHealthcare reserves the right to validate the information provided and request additional documentation.

**Signature of person who completed this form:**

**Printed name:**

**Title:**

**Date of submission:**

## Required documents

Your application will not be evaluated without the following required documents:

- Proof of accreditation
- State license
- Proof of enrollment in individual state
- Medicaid plan(s), if applicable
- W-9 form

Additional documentation may be requested as part of the review process.

<sup>1</sup>These criteria are for network participation and credentialing purposes only and do not determine member eligibility, coverage or medical necessity.

<sup>2</sup>UnitedHealthcare reserves the right to verify accreditation status.

<sup>3</sup>Plan participation is subject to availability and contracting requirements, and final determinations will be made by UnitedHealthcare.

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