Join our network request submission - Ancillary providers and centers

Home health and hospice service questionnaire

To join our network as a home health and hospice provider, email this completed questionnaire with any required documentation to **hhcnetwork@uhc.com.**

Should we proceed with contracting, the name provided on this questionnaire will be loaded into our billing and payment systems exactly as submitted. The use of any other name thereafter may cause billing and payment delays.

Go to **UHCprovider.com/join > Ancillary providers** for more details on joining our network, including required documentation, submission instructions and more.

Provider name

Provider type (Select all that apply)

- ☐ Home health e.g., skilled service such as nursing, OT, PT or ST)
- ☐ Hospice

Provider contact and billing information

Contact name:	
Billing address:	
Email:	Title:
Mailing address:	
Phone:	Practice website:
Fax:	

Do you provide services out of more than 1 branch location?

☐ Yes ☐ No

If yes, complete the following sections for each branch location. If you have more than 3 branches, please attach a separate sheet with a roster of all addresses.

Place of service address:

General questions

Current UnitedHealthcare participation status

☐ UnitedHealthcare commercial plans	State:
☐ UnitedHealthcare® Medicare Advantage	State:
☐ UnitedHealthcare Community Plan (Medicaid)	State(s):
☐ Doesn't participate in any of these UnitedHealthcare plans	

United Healthcare®

Medicare certified?

☐ Yes, Medicare number: _____

☐ No ☐ Pending

Medicaid certified?

☐ Yes, Medicaid number: _____

☐ No ☐ Pending

Geographic coverage

Please indicate the states where you're authorized to provide services:

☐ AL	☐ CO	☐ GU	☐ KS	☐ MI	☐ NV	☐ ND	☐ PR	☐ UT
☐ AK	☐ CT	☐ HI	☐ KY	☐ MN	☐ NH	☐ MP	☐ RI	☐ VT
☐ AZ	☐ DE	☐ ID	☐ LA	☐ MS	☐ HN	☐ OH	☐ SC	☐ VA
☐ AR	☐ DC	☐ IL	☐ ME	☐ MO	☐ NM	☐ OK	☐ SD	☐ VI
☐ AS	☐ FL	☐ IN	☐ MD	☐ MT	☐ NY	☐ OR	☐ TN	☐ WV
☐ CA	☐ GA	☐ IA	☐ MA	☐ NE	☐ NC	☐ PA	☐ TX	☐ WI

Counties covered by agency

*If you don't offer all services in all locations, please specify the services provided in each county.

_____ _____ _____

_____ _____ _____

Indicate whether you bill on a 1500 (HCFA 1500/CMS-1500/1500 HCF) or UB (UB92/UB04) claim form

Commercial	Medicaid
☐ HCFA 1500	☐ HCFA 1500
☐ UB	☐ UB

Notify us if you change your bill type. We'll need to execute a contract amendment before the changes can take effect. If you don't use the correct form, we'll be required to deny your claims.

Tax ID number (TIN)

TIN	National Provider Identifier (NPI) number	Associated legal name	Legal DBAs affiliated with provider
Ex: 987654321	*1234567891*	*Legal Name, Inc.*	*Doing business as [name]*

Home health services provided by your organization

If you provide services not listed, please provide a description with the appropriate billing code. Attach an additional sheet if needed.

☐ Enterostomal therapy	☐ Occupational therapy	☐ Registered dietitian
☐ Home health aide	☐ Phototherapy	☐ Respiratory therapy
☐ Medical social worker	☐ Physical therapy	☐ Skilled LPN nursing
☐ Respiratory therapy	☐ Postnatal services	☐ Skilled RN nursing
☐ Newborn care	☐ Private duty nursing (RN/LPN)	☐ Speech therapy

How many clients/members can you accommodate?

Quantity

Population(s) you service

☐ Adults ☐ Pediatric ☐ Patients ☐ Geriatrics ☐ Long-term care

Languages spoken by the provider and/or staff other than English

	Spoken	Written	Both	Communicate through an interpreter
Lanugage 1:	☐	☐	☐	☐
Lanugage 2:	☐	☐	☐	☐
Lanugage 3:	☐	☐	☐	☐

Do you use an American Sign Language interpreter? ☐ Yes ☐ No

Is the home health agency currently credentialed with UnitedHealthcare?

☐ Yes ☐ No

Attach the following documents when submitting your questionnaire

- **Current Form W-9**
- **Sample claim form showing the business name which the claims will be submitted under**

Information of individual completing this form

Name:	Email:
Date completed:	Title:
Phone number:	

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