

Request to join the UnitedHealthcare network reassessment request



Reconsideration requests

If you received an email stating that applications aren't being accepted for your provider type, you may request reconsideration by completing this form. Please include any new or relevant information that may support your request for review. All requests are evaluated based on current network needs. Please complete all fields to ensure your request is processed in a timely manner.

Contact name:

Contact email:

Is the contact a third-party organization representing the provider/medical group/facility on their behalf? Yes No

If yes, provide your organization's name:

Medical group/facility name:

Medical group/facility tax ID number (TIN):

Medical group/facility National Provider Identifier (NPI) number:

Provider name:

Provider NPI number:

Primary specialty or facility taxonomy:

Are you requesting to change the TIN associated with your current participation agreement? Yes No

If yes, please advise of the current TIN and the new TIN. Refer to your participation agreement for additional information regarding notification of a TIN change.

Current TIN:

New TIN:

Did you acquire, merge with or become affiliated with a provider/medical group/facility that is already under contract with UnitedHealthcare? This could be due to a provider's retirement, sale and/or transfer of assets. Yes No

If yes, please provide the current provider/medical group name/facility name and TIN .

Current provider/medical group name:

Current provider/medical facility name:

Current provider/medical facility TIN:

If the request is for a provider/medical group, are services rendered exclusively in a facility setting, such as a skilled nursing facility, assisted living facility, ambulatory surgery center or hospital?

Yes No



If the request is for a provider/medical group, are services rendered exclusively in a facility setting, such as a skilled nursing facility, assisted living facility, ambulatory surgery center or hospital?

Yes No

If the request is for a provider/medical group, are services rendered 100% through a telehealth modality? Yes No

Primary service/facility location: List address, city, state, county, ZIP code, phone and fax

Address:

City:

State:

ZIP code:

Phone:

Fax:

County:

Please list line(s) of business being requested:

Commercial

Medicare

Medicaid

Individual exchange plans

Veterans

*Medicare and Medicaid IDs may be required to be credentialed and contracted.

Are you currently or recently contracted with UnitedHealthcare as an employed physician? Yes No

If yes, please provide any known medical group name, state and TIN information.

Medical group name:

State:

TIN:

If none of the above applies, but you offer specialized services not currently available to our members within our network of physicians and facilities, please provide specific details about those services.

How to submit

- Once the form is completed, save the form to your files
- Then, **sign in** to the UnitedHealthcare Provider Portal with your One Healthcare ID
- Select the chat icon at the bottom-right corner of the page to connect with an advocate, 7 a.m.–7 p.m. CT

Please have the care provider's full name, tax ID number (TIN) and National Provider Identifier (NPI) number ready when you start your chat session.

If you have an assigned network contract manager, you can also contact them directly.

