Delegate Roster Submission Data Dictionary

Each record/row contains details specific to a unique provider as defined by their Provider Name, NPI, Location and TIN combination.

Field	Definition	Format Accepted	Required or Suggested
Newly Credentialed/Tin Addition/ Annual Roster Tab			
Original Credentialing Committee Date	Date on which the group first credentialed/approved the provider	MM/DD/YYYY MM/D/YYYY M/D/YYYY M/DD/YYYY MM-DD-YYYY MM-D-YYYY M-D-YYYY M-DD-YYYY	Required
Latest Re-Appointment/ Re-Credentialing Committee Approval Date	Date on which the group last recredentialed the provider; Delegate is required to report the most recent recredentialing events within 30 days of credentialing committee's approval.	MM/DD/YYYY MM/D/YYYY M/D/YYYY M/DD/YYYY MM-DD-YYYY MM-D-YYYY M-D-YYYY M-DD-YYYY	Required (if applicable)
Effective Date	Date on which the provider relationship is effective	MM/DD/YYYY MM/D/YYYY M/D/YYYY M/DD/YYYY MM-DD-YYYY MM-D-YYYY M-D-YYYY M-DD-YYYY	Required (if applicable)
Tax ID	Tax ID used for billing reasons	9 digits	Required
Last Name	Provider's last name	Open text	Required
First Name	Provider's first name	Open text	Required
Middle Name	Provider's Middle Name or initial	Open text	Required (if applicable)
Name Suffix (if applicable)	Provider suffix, if applicable	Open text	Required (if applicable)
[Primary/Secondary] Degree	Provider professional degree; comma-separated if multiple	AS; AUD; BA; BS; CA; CCC; CCM; CM; CNA; CNM; CO; CP; CPO; CRT; CS; CSW; DC; DD; DDS; DMD; DN; DNP; DO; DPM; EDD; EdS; FNP; HIS; LPC; LPN; LVN; MA; MD; MED; MS; MSN; MSN; MSW; MTH; ND; "NON"; "NON EDD"; NP; OD; OTR; PA; PHA; PHD; PSY; PT; RD; RN; RNA; RRT; RSW; SLP; VNA	Required
National Provider Identification	Provider's assigned National Provider Identification Number	number text	Required
Social Security Number	Identifies the provider's personal social security number and is suggested for participating Medicaid providers	Nine digit number	Suggested
NUCC Taxonomy Code	Provider's primary specialty taxonomy code	Open text	Suggested
Date of Birth	Provider's date of birth	MM/DD/YYYY MM/D/YYYY M/D/YYYY M/DD/YYYY MM-DD-YYYY MM-D-YYYY M-D-YYYY M-DD-YYYY	Suggested
Gender	Provider gender (Male or Female)	Male Female M F	Required
Race	Provider race Race options are aligned to the HL7 FHIR standards Level 1 and Office of Management and Budget. To provide additional descriptions, please reference Levels 1-3 of the HL7 FHIR Standards v3 Race: https://www.hl7.org/fhir/v3/Race/cs.html	American Indian or Alaska Native - 1002-5 Asian - 2028-9 Black or African American - 2054-5 Native Hawaiian or Other Pacific Islander - 2076-8 White - 2106-3 Other Race - 2131-1	Suggested
Ethnicity	Identifies the ethnicity of the provider Ethnicity options are aligned to the HL7 FHIR standards Level 1 and Office of Management and Budget. https://www.hl7.org/fhir/v3/Ethnicity/cs.html	Hispanic or Latino - 2135-2 Not Hispanic or Latino - 2186-5	Suggested
How do you identify your sexual orientation? (list all that apply)	Identifies the sexual orientation of the provider	S - Straight L - Lesbian G - Gay B - Bisexual P - Pansexual Q - Queer A - Asexual A sexual orientation not listed here (specify): _____ PNA - Prefer Not to Answer	Suggested- Colorado ONLY

How do you describe your current gender identity? (list all that apply)	The gender(s) the provider currently identifies as	F - Female M - Male TF/TW - Transgender Female/Transgender Women TM - Transgender Male/Transgender Man NB - Non-Binary TS - Two-spirit I - Intersex GQ/GF - Gender Queer/Gender Fluid A gender identity not listed here (specify): _____ PNA - Prefer not to answer	Suggested- Colorado ONLY
What was your sex assigned at birth?	Identifies the sex as assigned at birth of the provider	Y = Yes N = No ND - Not Designated at Birth PNA - Prefer Not to Answer	Suggested- Colorado ONLY
Do you have a disability?	Identifies whether the provider have a disability	Y - Yes N - No PNA - Prefer Not to Answer	Suggested- Colorado ONLY
Tax ID's Incorporation Status	The incorporation status for the Tax ID under which the provider bills for services rendered	'CHTD' - Chartered 'CORP' - Corporation 'INC' - Incorporation 'LLC' - Limited Liability Corporation 'LLP' - Limited Liability Partnership 'LP' - Limited Partnership 'LTD' - Limited 'PA' - Professional Association 'PC' - Professional Corporation 'PLC' - Professional Licensed Corp 'PLLC' - Professional Ltd Licensed Corp 'PS' - Professional Services 'PSC' - Professional Services Corporation 'SC' - Service Corporation	Suggested
Name of Legal Owner Tax id number	Owner's name registered on the W-9 Required when Tax ID Number is not yet established with United (ex. Reporting a new Tax I.D. or an individual's Tax I.D.)	Open text	Required (if applicable)
Group/Site Location Name DBA	The Location Name, which is the DBA of the TaxID, commonly used by staff and/or patients (most likely the name to be used on a Directory)	Open text	Suggested
Group NPI number	Group NPI Number; required for Indiana Medicaid	10 digits	Suggested
Merchant ID #	# issued by credit card processor (POS). Can be obtained from Practice Administrator. Used for Providers eligible for Care Cash payment	15 numerical digits	Suggested
Address Type P = Practice C = Billing and Practice M = Mail Only F= Facility Address	Required for Practice and Combination addresses; Address type for the listed practice location P = is the Practice address where a member can schedule and be seen by appointment. Practice address may also include locations where the provider does not see patients by appointment on a regular schedule such as an on call/covering location, however, such address locations should always be suppressed from the directories. C = is an address type where the practice and billing address are the same M = is the address type where the provider will only receive mail. F = is the Facility place of service address where a Hospital Based Provider provides service one or more days per month and may bill for service. Facilities includes, but not limited to hospitals, surgery centers, nursing homes, etc.)	Open text	Required (if applicable)
Is this address the provider's primary or secondary practice address? (Primary or Secondary)	Is address listed the Providers primary practice address or secondary **Practice address is used only if provider schedules patients at this location and should not be reported for locations where the provider is on call/covering.**	Primary Secondary P S	Required
Facility Location Name	For Hospital Based Providers, the practice/place of service address is the facility address where services are performed. Name of the facility is required.	Open text	Required (if applicable)
Address	Street 1 address of the practice location	Open text	Required
Address	Street 2 address of the practice location (building, suite, etc.)	Open text	Required (if applicable)
City	City of the practice location	Open text	Required
State	State of the practice location	Open text	Required
Zip Code	Zip code of the practice location	Open text	Required
County	County of the practice location	Open text	Suggested
Phone Number	Phone number used by patients to schedule an appointment at the practice location For Hospital Based Providers, the phone number should only one where by which the provider can be contacted e.g. medical group administration. Typically not the actual FACILITY PHONE NUMBER(e.g. hospital, nursing home, etc.).	########## ###-###-#### (###) ###-##### (###)#######	Required
Fax number	Fax number used primarily for appointment-related needs For Hospital Based Providers, the fax number should only one where by which the provider can be contacted e.g. medical group administration. Typically not the actual FACILITY FAX (e.g. hospital, nursing home, etc.).	########## ###-###-#### (###) ###-##### (###)#######	Suggested

Should Address appear in the Directory	Indicates if the providers place of service address should be listed in United's directories. Place of service addresses where the provider does not see patients by appointment on a regular basis must be reported, as "no" to suppress the provider from United's directories. For Hospital Based Providers, the practice/place of service address is the facility address where services are performed. For Texas requirement directory to be set to Y	Yes No Y N	Required
PCP Capacity: How many members will the Provider accept at this Place of Service location? (Required for Ohio and Indiana Medicaid only)	Maximum number of members Primary Care Provider (PCP) accepts at the listed practice location Required for Ohio & Indiana Medicaid Note: Indiana PCPs are limited to two place of service addresses for which members can be assigned.	Open text	Required, if applicable
Does this office location use Nurse Practitioner or Physician Assistant?	Identifies if the office location uses Nurse Practitioner, Physician Assistant or neither Required for Indiana Medicaid	NP = Nurse Practitioner PA = Physician Assistant N = Neither	Suggested
Weekday Work Hours (Monday thru Friday)	The hours the practice location is open to care for members for each weekday. If location is open 24 hours, value will likely be 12:00 AM - 12:00 AM.	HH:MM am HH:MMam HH:MM AM HH:MMAM HH:MM pm HH:MMpm HH:MM PM HH:MMPM H:MM am H:MMam H:MM AM H:MMAM H:MM pm H:MMpm H:MM PM H:MMPM Closed	Required
Email Address of Individual Provider	Provider email address	xxxxxxxxx@xxxx.com	Suggested
Consent to publish Individual Provider Email Address (Y or N) (Publication of Provider Email Address will default to No, unless otherwise noted)	Answers the question - Does the provider permit UHC to publish the providers email address in the UHC directory? (Yes or No) Publication of Provider Email Address will default to No, unless otherwise noted	Yes No Y N	Suggested
If this place of service location is accessible by public transportation, please list the types of public transportation that are accessible	Identifies the types of public transportation available acessible for the place of service location Indiana Medicaid	Bus Subway Regional Train Other: Please Specify	Suggested
Is this Location Handicap Accessible? (Y or N)	Answers the question: does the practice location meet ADA Accessibility criteria? (Yes or No) Handicap accessibility is required for Indiana, Ohio and Texas Medicaid	Yes No Y N	Required (if applicable)
If a place of service location is Handicap Accessible, please list all available Handicapped Accessibility Services at the location It is acceptable to list multiple services, separated by comma	List all areas of handicap accessibility. Types may include: • T = EXAM TABLE/SCALE/CHAIR • G = GURNEYS & STRETCHERS • PL = PORTABLE LIFTS • RE = RADIOLOGIC EQUIPMENT • S = SINGAGE & DOCUMENTS Indiana Medicaid	Open text	Suggested
Does this Practice Location serve Children with Special Needs (CSHCN)?	Identifies if the practice location serves Children with Special Needs Required for Indiana Medicaid	Yes No Y N	Suggested
Languages Spoken at this Location (English will be listed as default, unless otherwise noted)	Languages other than English spoken by the provider or staff; comma-separated if fluent in multiple languages Default will be limited to English if not provided	Open text	Required
Languages Written at this Location	Languages other than English written by the provider or staff; comma-separated if fluent in multiple languages	Open text	Suggested
Language Written By P = Provider S = Staff B = Both	Indicate if the language other than English is fluent by the provider, staff or both	Provider Staff Other P S O	Suggested
Telehealth Services Type	Identifies the type of telehealth services the provider offers the patients at this location A = Audio only V= Audio/Video N= Neither/not offered "Blank" = default to unknown	Open text	Suggested

Telehealth Scheduling Type	Describes if the telehealth visit is available to the patients within 15 minutes of the request (on-demand) or if a designated time is established to schedule the visit (scheduled). O= On-Demand S = Scheduled B = Both On Demand & Scheduled "Blank" = default to unknown	Open text	Suggested
Telehealth Services Availability Patient Indicator	Defines if the provider offers telehealth services for new patients, existing patients or both new and existing patients. N = New Patients only E = Existing only B = Both New & Existing Patients "Blank" = default to unknown	Open text	Suggested
Practice Web Address (URL)	Website URL specific to the practice location	Open text	Suggested
Practice Web Address (URL) Type: T = Capable of accessing URL to schedule telehealth appointments I = Capable of accessing URL to schedule in-person appointments S = Single Sign-On portal where patients login to interface with the provider office "Blank" indicates the practice web address is a general site that does not have appointment scheduling capabilities.	Identifies if the Practice Web Address (URL) includes functionality for patients to schedule Telehealth and/or in-person appointments, a single sign-on portal that the member logins to interface with the providers office or is a general website without the ability to schedule appointments.	T I S "Blank"	Suggested
Contact Name	Name of contact other than the provider for the location/group	Open text	Suggested
Contact Email Address	Email address of the location/group contact listed on the file For Hospital Based Providers, the email address should only one where by which the provider can be contacted e.g. medical group administration. Typically not the actual HBP provider email.	Open text	Suggested
Contact Type (e.g. office manager, billing, credentialing, etc.)	Title of the location/group contact listed on the file	Open text	Suggested
Contact Phone/Fax Number	Phone/fax of the location/group contact listed on the file For Hospital Based Providers, the phone or fax should only one where by which the provider can be contacted e.g. medical group administration. Typically not the actual HBP provider's phone or fax.	10 numeric digits with or without hyphens/parenthesis	Suggested
Billing Address	Street 1 address used to bill for services at the practice location	Open text	Required
Billing Address	Street 2 address used to bill for services at the practice location	Open text	Required
Billing City	City used to bill for services at the practice location	Open text	Required
Billing State	State used to bill for services at the practice location	Open text	Required
Billing Zip	Zip used to bill for services at the practice location	Open text	Required
Billing Phone Number	Phone number used for billing correspondence	Open text	Required
Billing Fax Number	Fax number used for billing correspondence	Open text	Suggested
Type of Cultural Competence Training Medicaid Only	Designates cultural competency training completed by the provider	CSS - Communication Skills - Soft Skills CLA - Communication Skills - Language Availability CIS - Communication Skills - Interpreter Services LGB - LGBT Communities SC - Senior Care FCP - Financially Challenged Patients RIP - Refugee or Immigrant Patients PWD - People with Disabilities HL - Homeless UNS - Unspecified	Suggested
Effective/Completion Date of Cultural Competency Training Medicaid Only	Date cultural competency training was completed	MM/DD/YYYY MM/D/YYYY M/D/YYYY M/DD/YYYY MM-DD-YYYY MM-D-YYYY M-D-YYYY M-DD-YYYY	Suggested
Expiration Date of Cultural Competency Training Medicaid Only	Date cultural competency training certification expires	MM/DD/YYYY MM/D/YYYY M/D/YYYY M/DD/YYYY MM-DD-YYYY MM-D-YYYY M-D-YYYY M-DD-YYYY	Suggested
Essential Community Provider (ECP): Provider serves predominantly low-income, medically underserved individuals Medicaid Only	Designate if the provider serves predominantly low-income, medically underserved individuals	Y=Yes, is a designated ECP provider N=No, is not a designated ECP provider	Suggested
Medicaid Number for this Provider at this location (If group participates in Medicaid Products, this is a mandatory field)	Required if participating with Medicaid Line of Business; list the Provider Medicaid ID by location	12345678	Required (if applicable)
Medicaid: State Issuing	Required if participating with Medicaid Line of Business; State in which the provider Medicaid ID is active	State abbreviation Open text	Required (if applicable)
Medicare Number for this Provider	Provider Medicare ID	Open text	Suggested

Primary Practicing Specialty	The primary specialty practiced by the provider and deemed qualified by the Delegate	Open text	Required
Board Certification Status	Identifies the provider's certification status by ABMS or an approved Board as listed in the UHC Credentialing Plan	C= Certified E= Eligible N=Not Certified X=Not Applicable	Required (if applicable)
Board Certification Effective Date	The effective date the provider became certified by ABMS or approved acceptable Board as listed in the UHC Credentialing Plan	MM/DD/YYYY MM/D/YYYY M/D/YYYY M/DD/YYYY MM-DD-YYYY MM-D-YYYY M-D-YYYY M-DD-YYYY	Required (if applicable)
Board Certification Expiration Date	The date the provider's certification by ABMS, or approved acceptable Board as listed in the UHC Credentialing Plan, expires	MM/DD/YYYY MM/D/YYYY M/D/YYYY M/DD/YYYY MM-DD-YYYY MM-D-YYYY M-D-YYYY M-DD-YYYY	Required (if applicable)
Accepting New & Existing Patients for All Lines of Business; Refer to columns DB through DF if status varies by Line of Business	Answers the question: is this provider accepting new and existing patients by specialty for all lines of business? (Yes or No) If left blank, UHC will default to, yes, accepting new and existing patients for all lines of business. Required for all provider types. Variations by lines of business may be reported under columns DB through DF	Yes No Y N	Required
Secondary Practicing Specialty	The secondary specialty(ies) practiced by the provider and deemed qualified by the Delegate	Open text	Required (if applicable)
Board Certification Status 2	Identifies the providers specialty certification status by ABMS or an approved Board as listed in the UHC Credentialing Plan	C= Certified E= Eligible N=Not Certified X=Not Applicable	Required (if applicable)
Board Certification 2 Effective Date	The effective date the provider became certified by ABMS or approved acceptable Board as listed in the UHC Credentialing Plan	MM/DD/YYYY MM/D/YYYY M/D/YYYY M/DD/YYYY MM-DD-YYYY MM-D-YYYY M-D-YYYY M-DD-YYYY	Required (if applicable)
Board Certification Expiration Date	The date the provider's certification by ABMS, or approved acceptable Board as listed in the UHC Credentialing Plan, expires	MM/DD/YYYY MM/D/YYYY M/D/YYYY M/DD/YYYY MM-DD-YYYY MM-D-YYYY M-D-YYYY M-DD-YYYY	Required (if applicable)
Area of Expertise (Special Experience, Skills and Training)	Areas of Expertise helps identify specialized services of care that are distinct from practicing specialty which includes special experience, skills and training for providers within our in- network directories. Click here for the link to our current definitions: Area of Expertise Definitions	2-4 digit alphanumeric code Example: HV, HIMP, MAT1, CIL	Suggested
For the TAX ID, is this Provider a PCP, Specialist, Hospitalist, Hospital Based Provider or Locum Tenen	Description of a provider's classification at this location (i.e. PCP, Specialist, etc.) Providers listed as HBP is confirmation the provider does not practice in an office setting Hospital Based Providers include: Anesthesiology, Assistant Surgeon, Emergency Medicine, Hospitalist, Neonatology, Pathology, and Radiology.	PCP, Specialist, Hospitalist, Hospital-base Provider or Locum Tenen	Required
Advanced Practice Clinicians (aka Midlevels) Supervising Specialty (provide the specialty, not provider name)	Specialty of the Advanced Practice Clinician's supervising physicians practicing specialty. For Advanced Practice Clinicians that do not require supervision, provide the primary specialty of the practice. For Advanced Practice Clinicians that do require supervision, provide the specialty of the supervising physician, not the name. If Supervising Provider is classified as HBP for the Tax ID, the Mid-Level to match.	Open text	Required (if applicable)
Does your office location perform In-Office Lab procedures?	Indicate if the provider's listed office location has the ability to perform in-office laboratory drawings	Yes No Y N	Required (if applicable)
CLIA Certification Number	List the Clinical Laboratory Improvement Amendment (CLIA) certification number if the practice location perform in-office laboratory drawings or procedures	Open text	Required (if applicable)
State License Number	Provider license number	Open text	Required
State in which License is Held	State in which the provider license is effective	Open text	Required

State License Number Expiration Date	Date when the provider license expires	MM/DD/YYYY MM/D/YYYY M/D/YYYY M/DD/YYYY MM-DD-YYYY MM-D-YYYY M-D-YYYY M-DD-YYYY	Suggested
DEA Number	Provider DEA license number	Open text	Suggested
DEA Number Expiration Date	Date when the provider DEA license expires	MM/DD/YYYY MM/D/YYYY M/D/YYYY M/DD/YYYY MM-DD-YYYY MM-D-YYYY M-D-YYYY M-DD-YYYY	Suggested
CDS Number Indiana Medicaid Providers: the registration number or notation of N/A is required	Providers state issued Controlled Dangerous Substance registration number	Open text	Required, if applicable
Name of Admitting Hospital Affiliation(s) or Covering Group/Provider name	Name of Hospital or covering provider/group name that will admit members on your behalf Required for all MD's and DO's, except Dermatologists. Also required for NP's and PA's For all Hospital Based Provider (Physician and Mid-level) the name of the Hospital facility is required.	Open Text	Required
Admitting Hospital Affiliation Status	Identify the status of the providers Hospital Privileges (not applicable for covering arrangements). If left blank, we will default to Active status. Required for New Jersey Medicaid	AC = Active ACA = Assistant Attending ACT = Active Admitting ADJ =Adjunct Staff ADM = Admitting AFF = Affiliate ASC = Associate ATA = Assistant Adjunct ATT = Attending CLP = Clinical Privileges CN = Consulting Admitting CON = Consulting COU = Courtesy CT = Courtesy Admitting DAP = Deferred Admitting Privileges HON = Honorary NAC = Active Non-Admitting NAN = Non-Admitting NCN = Consulting Non-Admitting NCT = Courtesy Non-Admitting NPR = Provisional Non-Admitting NTP = Temporary Non-Admitting PR = Provisional Admitting PRO = Provisional SRA = Senior Attending SUP = Supervisor TEM = Temporary ; TP = Tempoary Admitting ; UNK = Unknown	Required (if applicable)
Medical School	Name of the school where provider completed professional education	Open text	Suggested
Medical School Completion Date	Year in which the provider graduated from the professional school	MM/DD/YYYY MM/D/YYYY M/D/YYYY M/DD/YYYY MM-DD-YYYY MM-D-YYYY M-D-YYYY M-DD-YYYY	Suggested
Patients Age Limits	If the provider has an age limitation, youngest patient age the provider can treat at this location and maximum patient age the provider can treat at this location Required for Ohio providers & Indiana Medicaid PMPs	Open text with exception noted below Indiana Medicaid PMP's must select from the following ranges; please note the ranges marked with an asterisk are not available to Internal Medicine & OB/GYN practitioners: None* 0 - 2 years * 0 - 12 years* 0 - 17 years* 0 - 20 years * 3+ years * 13+ years 13 - 17 years 13 - 20 years 17+ years 21+ years 65 + years	Required, if applicable
Patient Gender Restrictions	If the provider has a gender limitation, which patient gender the provider treats at this location Required if gender restrictions apply	Yes No Y N	Required (if applicable)
Scope of Practice Required for Indiana Medicaid OB/GYNs and Family Practitioners	Identifies if the scope of women care provided by OB/GYNs or Family Practitioner's	Indiana Medicaid PMPs and OB/GYNs are required to identify one designation: B = All Women (OB/GYN) O = OB Only (OB/GYN) O = OB (Family Practitioners) N/A = Family Practitioner does not provide OB care	Required, if applicable
Delivery Privileges or Covering Arrangements Required only for Indiana Medicaid PMPs providing OB care	Identifies hospital delivery privileges or covering arrangements for Indiana Medicaid OB/GYNs and Family Practitioners whose scope of practice includes obstetrics	Open Text	Required, if applicable

UnitedHealthcare Accepting New & Existing Patients Commercial Products only	Identifies if the provider accepting new and existing patients for UnitedHealthcare Commercial members. Only required if the providers panel status is unique by lines of business. Provider's with closed or who limit accepting new patient status to existing patients will still appear in the directory with their accepting new patient status limitations.	O = Open C = Closed E = Existing Only	Required (if applicable)
Oxford Health Plan Accepting New & Existing Patients	Identifies if the provider accepting new and existing patients for Oxford Health Plan members. Only required if the providers panel status is unique by lines of business. Provider's with closed or who limit accepting new patient status to existing patients will still appear in the directory with their accepting new patient status limitations.	O = Open C = Closed E = Existing Only	Required (if applicable)
Medicare Accepting New & Existing Patients	Identifies if the provider accepting new and existing patients for Medicare members. Only required if the providers panel status is unique by lines of business. Provider's with closed or who limit accepting new patient status to existing patients will still appear in the directory with their accepting new patient status limitations.	O = Open C = Closed E = Existing Only	Required (if applicable)
Medicaid Accepting New & Existing Patients	Identifies if the provider accepting new and existing patients for Medicaid members. Only required if the providers panel status is unique by lines of business. Provider's with closed or who limit accepting new patient status to existing patients will still appear in the directory with their accepting new patient status limitations.	O = Open C = Closed E = Existing Only	Required (if applicable)
UnitedHealthcare Participating Provider?	Applicable to groups who are allowed to opt in/out of certain products. When the participation agreement between UHC and the Group allows individual providers to Opt In or Out of specific lines of business, identify if the Provider has agreed to Opt In to UHC's Commercial line of business.	Yes No Y N	Required (if applicable)
Oxford Health Plan Participating Provider?	When the participation agreement between UHC and the Group allows individual providers to Opt In or Out of specific lines of business, identify if the Provider has agreed to Opt In to UHC's Oxford line of business.	Yes No Y N	Required (if applicable)
Medicare Participating Provider?	When the participation agreement between UHC and the Group allows individual providers to Opt In or Out of specific lines of business, identify if the Provider has agreed to Opt In to UHC's Medicare line of business.	Yes No Y N	Required (if applicable)
Medicaid Participating Provider?	When the participation agreement between UHC and the Group allows individual providers to Opt In or Out of specific lines of business, identify if the Provider has agreed to Opt In to UHC's Medicaid line of business.	Yes No Y N	Required (if applicable)
Veterans Affairs Community Care Network ("VA CCN") Provider?	When the participation agreement between UHC and the Group allows individual providers to Opt In or Out of specific lines of business, identify if the Provider has agreed to Opt In to UHC's VA CCN line of business.	Yes No Y N	Required (if applicable)
Cred_Recredentialing Roster Tab: to facilitate ongoing monthly updates of delegates approvals at time of recredentialing.			
NPI (National Provider Identification)	Provider's assigned National Provider Identification Number	number text	Required
Last Name	Provider's last name	Open text	Required
First Name	Provider's first name	Open text	Required
Primary Degree	Provider professional degree; comma-separated if multiple	AS; AUD; BA; BS; CA; CCC; CCM; CM; CAN; CNM; CO; CP; CPO; CRT; CS; CSW; DC; DD; DDS; DMD; DN; DNP; DO; DPM; EDD; EdS; FNP; HIS; LPC; LPN; LVN; MA; MD; MED; MS; MSN; MSW; MTH; ND; "NON"; "NON EDD"; NP; OD; OTR; PA; PHA; PHD; PSY; PT; RD; RN; RNA; RRT; RSW; SLP; VNA	Required
Primary Practicing Specialty	The primary specialty practiced by the provider and deemed qualified by the Delegate	Open text	Required
Original Credentialing Committee Date	Date on which the group first credentialed/approved the provider	MM/DD/YYYY MM/D/YYYY M/D/YYYY M/DD/YYYY MM-DD-YYYY MM-D-YYYY M-D-YYYY M-DD-YYYY	Required
Latest Re-Appointment/ Re-Credentialing Committee Approval Date	Date on which the group last recredentialed the provider; Delegate is required to report the most recent recredentialing events within 30 days of credentialing committee's approval.	MM/DD/YYYY MM/D/YYYY M/D/YYYY M/DD/YYYY MM-DD-YYYY MM-D-YYYY M-D-YYYY M-DD-YYYY	Required (if applicable)
State	State of the primary practice location	Open text	Required
Updates Tab			
Change Type R=Remove A=Add	Identifies if the transaction being requested is to add or remove the demographic reported	R Remove A Add	Required

Effective Date of Change	Identifies the date the demographic change occurred	MM/DD/YYYY MM/D/YYYY M/D/YYYY M/DD/YYYY MM-DD-YYYY MM-D-YYYY M-D-YYYY M-DD-YYYY	Required
Termination tab (full term/tin term)			
Termination date	Date in which provider is no longer at the group/practice	MM/DD/YYYY MM/D/YYYY M/D/YYYY M/DD/YYYY MM-DD-YYYY MM-D-YYYY M-D-YYYY M-DD-YYYY	Required
Reason for termination	Reason provider is no longer with the group or tin listed for termination. UHC will default to Provider Left Group if omitted in the submission	44 - Deceased 45 - Retired 46 - Left Group 74 - Involuntary for Loss of License, License restriction, state or federal sanction	Required
Provider Reassignment or Recommendation	Identifies the provider the members should be reassigned to.	Open text	Suggested
Provider Culture Training			
Name of Practice	The Location Name, practice/DBA commonly used by staff and/or patients.	Open text	Suggested- Colorado ONLY
Address	Street address of the practice location	Open text	Suggested- Colorado ONLY
Type of Training	Identifies the type(s) of culture training completed by the provider/provider staff.	Culture Competency Anti-bias Structural Racism Racial Justice Health Equity Allyship Other	Suggested- Colorado ONLY
Training Provided By	Name of organization that provided training.	Open text	Suggested- Colorado ONLY
Course Duration (in hours or days)	Identifies the length of time for the course/training.	HH:MM H:MM	Suggested- Colorado ONLY
# of Providers Who Attended the Training	Identifies the number of practitioners from the practice who participated in the training.	number text	Suggested- Colorado ONLY
# of Front Office Staff Who Attended the Training	Identifies the number of practitioners of practice staff who participated in the training.	number text	Suggested- Colorado ONLY
Date Completed	Identifies the date the training was completed	Open text	Suggested- Colorado ONLY
Certificate or CME awarded? (Y/N)	Identifies if the practice participants received a certificate of complete or CME credit upon completion.	Yes No Y N	Suggested- Colorado ONLY