

Join our network request submission – Ancillary providers and centers

National ancillary medical benefit health care facility questionnaire

To join our network as a national ancillary medical benefit health care facility, complete this form and visit uhcprovider.com/contactus to connect with us through chat for submission instructions.

Go to [Ancillary providers](#) for more details on joining our network, including required documentation and submission instructions.

Provider type (select all that apply to your entity*):

Ambulatory infusion suite

Home infusion

Specialty pharmacy

Hemophilia treatment center

Eligibility criteria

Joint Commission on Accreditation of Healthcare Organizations (JCAHO), Utilization Review Accreditation Commission (URAC), Community Health Accreditation Program (CHAP) or Accreditation Commission for Health Care (ACHC) or The Compliance Team (TCT)

JCAHO, URAC, CHAP, TCT or ACHC accreditation

URAC accreditation

Federally funded covered entity in the 340B Drug Pricing Program

National Provider Identifier (NPI) number taxonomy code: 261QI0500X

Home-based short-term acute drugs and long-term chronic medications administered by a nurse

National geographic service area**

NPI taxonomy code: 3336S0011X

* Excludes physician-based infusion clinics and hospital-based infusion clinics.

** Hospital-owned specialty pharmacies must be pre-approved for medical benefit contracting. Hospital-owned specialty pharmacies will be contracted to dispense medications only within the physical geographic coverage.

Provider type (select all that apply to your entity*):

Ambulatory infusion suite	Home infusion	Specialty pharmacy	Hemophilia treatment center
Eligibility criteria			
	NPI Taxonomy code: 3336H0001X	Dispensing of medications to physician office or outpatient rehabilitation hospital clinic	
		NPI taxonomy code: 3336S001X	
Place of service = 12 (billed with -SS modifier)	Place of service = 12	Place of service = 11	Place of service = 12

Tax ID number (TIN)

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

If additional space is needed, please submit a separate attachment**Provider contact and billing information**

Contact name:	Title:
Contact email:	Phone number:
Mailing address:	
Practice website URL:	
Billing address:	

* Excludes physician-based infusion clinics and hospital-based infusion clinics.

** Hospital-owned specialty pharmacies must be pre-approved for medical benefit contracting. Hospital-owned specialty pharmacies will be contracted to dispense medications only within the physical geographic coverage.

Service information

A sample claim form for each provider type you are applying for (e.g., ambulatory infusion suite, home infusion, specialty pharmacy and/or hemophilia treatment 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
UnitedHealthcare® Medicare Advantage

We require Medicare enrollment to include you in UnitedHealthcare Community Plan. Please provide dated Medicare participation documentation.

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

Please provide 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, please indicate which products and states you are seeking a contract for: Medicare & Retirement Commercial plan(s) Community Plan(s)

Update the names of these plans as indicated above

Please itemize specific plans by state:

Please describe the classes of trade to which you acquire medications with manufacturers or wholesalers:

Please 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:

Service categories (applicable only to home infusion, specialty pharmacy and ambulatory infusion suite)

Acute Home infusion categories	Chronic Home infusion/specialty pharmacy/ambulatory infusion suite categories			
Anti-coagulation	Alcohol dependence	Diagnostic	Interstitial cystitis	Psoriasis
Anti-emetic IV therapy	Anemia	Endocrine	Macular degeneration	Pulmonary hypertension
Anti-infective therapy	Anticoagulants	Enzyme deficiency	Monoclonal antibody miscellaneous	Rheumatoid arthritis
Catheter insertion and maintenance supplies	Antiemetic	Gaucher disease	Multiple sclerosis	RSV prevention
Chemotherapy infusion	Antipsychotic	Hematologic	Neutropenia	Severe spasticity
Enteral nutrition	Asthma	Hemophilia	Oncology - injectable	Thrombolytic agents prevention
Hydration	Biologics	Hepatitis B	Oncology - oral	Transplant
Pain management	Blood-modifying agent	Hepatitis C	Oncology - multiple sclerosis	Uveitis
Total parenteral nutrition	Cardiovascular/ heart failure	HIV/Aids	Ophthalmic/ optic	These are the only drug categories available for medical benefit contracting based on coverage. Category inclusion contingent on provider type.
Aerosolized drug therapy	Cervical dystonia	Inflammatory	Osteoarthritis	
Chelation therapy	CNS agents	Immune globulin	Osteoporosis	

Service categories (applicable only to home infusion, specialty pharmacy and ambulatory infusion suite) (cont.)

Acute Home infusion categories	Chronic Home infusion/specialty pharmacy/ambulatory infusion suite categories			
Inotropic	Cystic fibrosis	Immune modulator	Pain management	These are the only drug categories available for medical benefit contracting based on coverage. Category inclusion contingent on provider type.
	Dermatologic	Infertility	Parkinson's disease	

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.

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
- Medicare enrollment status
- Proof of enrollment in individual state
- Medicaid plan(s), if applicable
- W-9

Insurance coverage provided by or through UnitedHealthcare Insurance Company or its affiliates. Health plan coverage provided by UnitedHealthcare of Arizona, Inc., UHC of California DBA UnitedHealthcare of California, UnitedHealthcare Benefits Plan of California, UnitedHealthcare of Colorado, Inc., UnitedHealthcare of the Mid-Atlantic, Inc., MAMSI Life and Health Insurance Company, UnitedHealthcare of New York, Inc., UnitedHealthcare Insurance Company of New York, UnitedHealthcare of Oklahoma, Inc., UnitedHealthcare of Oregon, Inc., UnitedHealthcare of Pennsylvania, Inc., UnitedHealthcare of Texas, Inc., UnitedHealthcare Benefits of Texas, Inc., UnitedHealthcare of Utah, Inc., UnitedHealthcare of Washington, Inc., Optimum Choice, Inc., Oxford Health Insurance, Inc., Oxford Health Plans (NJ), Oxford Health Plans (CT), Inc., All Savers Insurance Company, Tufts Health Freedom Insurance Company or other affiliates. Administrative services provided by OptumHealth Care Solutions, LLC, OptumRx, Oxford Health Plans LLC, United HealthCare Services, Inc., Tufts Health Freedom Insurance Company or other affiliates. Behavioral health products provided by U.S. Behavioral Health Plan, California (USBHPC), United Behavioral Health (UBH), or its affiliates.