

# 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, complete this questionnaire with any required documentation and visit [UHCprovider.com/contact](https://UHCprovider.com/contact) to connect with us through chat for submission instructions.

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](https://UHCprovider.com/join) > **Ancillary providers** for more details on joining our network, including required documentation, participation 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:

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## 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

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

### 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**

HCFA 1500

UB

**Medicaid**

HCFA 1500

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

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

**Do you provide Home and Community Based Services (HCBS)?**

Yes      No

**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
Language 1:				

## Languages spoken by the provider and/or staff other than English (cont.)

	Spoken	Written	Both	Communicate through an interpreter
Lanugage 1:				
Lanugage 1:				

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:	

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.