

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.

Effective January 2025

Field	Definition Effective January 20	Format Accepted	Required or Suggested
	Newly Credentialed/Tin Addition/	·	. 55
Original Credentialing Committee	Date on which the group first credentialed/approved the provider	MM/DD/YYYY	Required
Date		MM/D/YYYY	·
		M/D/YYYY	
		M/DD/YYYY	
		MM-DD-YYYY	
		MM-D-YYYY	
		M-D-YYYY	
		M-DD-YYYY	
Latest Re-Appointment/ Re-	Date on which the group last recredentialed the provider; Delegate is required to report	MM/DD/YYYY	Required (if applicable)
Credentialing Committee Approval	the most recent recredentialing events within 30 days of credentialing committee's	MM/D/YYYY	
Date	approval.	M/D/YYYY	
		M/DD/YYYY	
	If the provider has been originally credentialed in the last 36 months, and is not due for	MM-DD-YYYY	
	recedentialing, enter their original credentialing date.	MM-D-YYYY	
		M-D-YYYY	
		M-DD-YYYY	
Effective Date	Date on which the provider's participation is effective.	MM/DD/YYYY	Required (if applicable)
		MM/D/YYYY	
	Required if the effective date is going to be after the original committee date.	M/D/YYYY	
		M/DD/YYYY	1
	Also required for hospital based providers.	MM-DD-YYYY	
		MM-D-YYYY	1
		M-D-YYYY	
		M-DD-YYYY	
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	Suggested (if applicable)
Name Suffix	Provider suffix, if applicable	Open text	Suggested (if applicable)
(if applicable)			
[Primary/Secondary] Degree	Provider professional degree;	AS, AUD, BA, BS, CA, CCC, CCM, CM, CAN, CNM, CO, CP, CPO,	Required - Primary
		CRT, CS, CSW, DC, DD, DDS,	Suggested - Secondary
		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	
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:	Nine digit number	Suggested
	-participating Medicaid providers		
	-participating Veterans Affairs Community Care Network (VA CCN) providers		
NUCC Taxonomy Code	Provider's primary specialty taxonomy code	Open text	Suggested
Date of Birth	Provider's date of birth	MM/DD/YYYY	Suggested
l		MM/D/YYYY	1
l	suggested for:	M/D/YYYY	1
l	-participating Medicaid providers	M/DD/YYYY	1
l	-participating Veterans Affairs Community Care Network (VA CCN) providers	MM-DD-YYYY	1
l		MM-D-YYYY	1
		M-D-YYYY	
		M-DD-YYYY	
Gender	Provider gender (Male or Female)	Male	Required
		Female	
l		м	1
		F	
Race	Provider race	open text	Suggested
ĺ			1
	Race options are aligned to the Health Level Seven (HL7) FHIR standards Level 1 and		1
	Office of Management and Budget.		1
			1
l	To provide additional descriptions, please reference Levels 1-3 of the HL7 FHIR Standards		1
l	v3 Race:		1
l			1
	http://terminology.hl7.org/CodeSystem/v3-Race		
Ethnicity	Identifies the ethnicity of the provider	open text	Suggested
			1
l	Ethnicity options are aligned to the Health Level 7 (HL7) FHIR standards Level 1 and Office		1
ĺ	of Management and Budget.		1
	http://terminology.hl7.org/CodeSystem/v3-Ethnicity		1
	•		

How do you identify your sexual			
	Identifies the sexual orientation of the provider	S - Straight	Suggested
orientation? (list all that apply)		L - Lesbian	Colorado ONLY
		G - Gay	
		B - Bisexual	
		P - Pansexual	
		Q - Queer	
		A - Asexual	
		A sexual orientation not listed here (specify):	
How do you describe your current	The gender(s) the provider currently identifies as	PNA - Prefer Not to Answer F - Female	Suggested
gender identity? (list all that apply)	The gender(s) the provider currently identifies as	M - Male	Colorado ONLY
gender identity: (tist att that apply)		TF/TW - Transgender Female/Transgender Women	COLOIAGO CIVET
		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	
What was your sex assigned at birth?	Identifies the sex as assigned at birth of the provider	Y = Yes	Suggested
		N = No	Colorado ONLY
		ND - Not Designated at Birth	
		PNA - Prefer Not to Answer	
Do you have a disability?	Identifies whether the provider have a disability	Y-Yes	Suggested
		N - No	Colorado ONLY
Tay ID's Incorporation Control	The incorporation status for the Text D and a which the world a bill for a side of the Text D and a which the world a bill for a side of the Text D and a which the world a bill for a side of the Text D and a which the world a bill for a side of the Text D and a which the world a bill for a side of the Text D and a which the world a bill for a bill fo	PNA - Prefer Not to Answer	Currented
Tax ID's Incorporation Status	The incorporation status for the Tax ID under which the provider bills for services rendered	'CHTD' - Chartered	Suggested
		'CORP' - Corporation 'INC' - Incorporation	1
		'INC' - Incorporation 'LLC' - Limited Liability Corporation	1
		'LLP' - Limited Liability Corporation 'LLP' - Limited Liability Partnership	1
		'LP' - Limited Partnership	1
		'LTD' - Limited	
		'PA' - Professional Association	1
		'PC' - Professional Corporation	
		'PLC' - Professional Licensed Corp	
		'PLLC' - Professional Ltd Licensed Corp	
		'PS' - Professional Services	
		'PSC' - Professional Services Corporation	
		'SC' - Service Corporation	
Name of Legal Owner Tax id number	Owner's name registered on the W-9	Open text	Required (if applicable)
	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.)		
Group/Site Location Name	The Location Name, which is the DBA of the TaxID, commonly used by staff and/or	Open text	Suggested
DBA	patients (most likely the name to be used on a Directory)		
Group NPI number	Group NPI Number	10 digits	Suggested
	required for Indiana Medicaid		
Merchant ID #	# issued by credit card processor (POS). Can be obtained from Practice Administrator.	15 numerical digits	Suggested
	# issued by credit card processor (POS). Can be obtained from Practice Administrator. Used for Providers eligible for Care Cash payment	-	
Merchant ID # Address Type	# issued by credit card processor (POS). Can be obtained from Practice Administrator. Used for Providers etigible for Care Cash payment Required for Practice and Combination addresses; Address type for the listed practice	15 numerical digits Open text	Suggested Required
Address Type	# issued by credit card processor (POS). Can be obtained from Practice Administrator. Used for Providers eligible for Care Cash payment	-	
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Address Type P = Practice C = Billing and Practice M = Mail Only F= Facility Address Is this address the provider's primary or secondary practice address? (Primary or Secondary) Facility Location Name Address Address	# issued by credit card processor (POS). Can be obtained from Practice Administrator. Used for Providers eligible for Care Cash payment 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.) 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. For Hospital Based Providers, the practice/place of service address is the facility address where services are performed. For Hospital Based Providers, the practice/place of service address is the facility address where services are performed. Name of the facility is required. Street 1 address of the practice location Street 2 address of the practice location (building, suite, etc.)	Open text Primary Secondary P S Open text Open text	Required Required Required Required (if applicable) Required (if applicable)
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Phone Number			
radinoci	Phone number used by patients to schedule an appointment at the practice location	#########	Required
		###-###-###	
	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.).		
Fax number	Fax number used primarily for appointment-related needs	#########	Suggested
T dx Hamber	Tax number asea primarily for appointment related needs	###-#####	ouggesteu
	For Hospital Based Providers, the fax number should be the one where the provider can be		
	contacted e.g. medical group administration. Typically not the actual FACILITY FAX (e.g.	(###)######	
	hospital, nursing home, etc.).	, ,	
Address Affiliation (appointment	For each provider's place of service address listed, select yes or no to identify the	Yes	Required
availability): Identify if the Provider	provider's appointment availability for the listed address.	No	
accepts appointments to see		Υ	
patients at least once a month at the	Yes (Y) = Yes, Provider does accept appointments at least once a month at this service	N	
listed place of service address.	location		
	No (N) = No, Provider does not accept appointments at least once a month at this service location		
PCP Capacity:	Maximum number of members Primary Care Provider (PCP) accepts at the listed practice	Open text	Required, if applicable
How many members will the Provider		Орептехт	nequired, if applicable
accept at this Place of Service	tocation		
location?	Required for Ohio & Indiana Medicaid		
(Required for Ohio and Indiana	Note: Indiana PCPs are limited to two place of service addresses for which members can		
Medicaid only)	be assigned.		
Does this office location use Nurse	Identifies if the office location uses Nurse Practitioner, Physician Assistant or neither	NP = Nurse Practitioner	Suggested
Practitioner or Physician Assistant?		PA = Physician Assistant	
	Required for Indiana Medicaid	N = Neither	
Weekday Work Hours	The hours the practice location is open to care for members for each weekday.	HH:MM am	Required
(Monday thru Sunday)	The flours the practice tocation is open to care for members for each weekday.	HH:MMam	Required
(**************************************	Example: 8:00am - 5:00pm	HH:MM AM	
	, , , , , , , , , , , , , , , , , , , ,	нн:ммам	
	If location is open 24 hours, value will likely be 12:00 AM - 12:00 AM.	HH:MM pm	
		HH:MMpm	
		HH:MM PM	
		нн:ммрм	
		H:MM am	
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		H:MMam	
		H:MMam H:MM AM	
		H:MMam H:MM AM H:MMAM	
		H:MMam H:MM AM H:MMAM H:MM pm	
		H:MMam H:MM AM H:MMAM H:MM pm H:MM pm	
		H:MMam H:MM AM H:MMAM H:MMAM H:MMpm H:MMpm H:MMpm	
		H:MMam H:MM AM H:MMAM H:MMpm H:MMpm H:MMpm H:MMpM	
Email Address of Individual Provider	Provider email address	H:MMam H:MM AM H:MMAM H:MMAM H:MMpm H:MMpm H:MMpm	Suggested
Email Address of Individual Provider	Provider email address	H:MMam H:MM AM H:MMAM H:MMpm H:MMpm H:MMpm H:MMpM	Suggested
Email Address of Individual Provider Consent to publish Individual	Provider email address Answers the question - Does the provider permit UHC to publish the providers email	H:MMam H:MM AM H:MMAM H:MMpm H:MMpm H:MM PM H:MMPM Closed	Suggested Suggested
		H:MMam H:MM AM H:MMAM H:MMpm H:MMpm H:MMPM Closed	
Consent to publish Individual	Answers the question - Does the provider permit UHC to publish the providers email address in the UHC directory? (Yes or No)	H:MMam H:MM AM H:MMAM H:MMpm H:MMpm H:MM PM H:MMPM Closed	
Consent to publish Individual Provider Email Address (Y or N)	Answers the question - Does the provider permit UHC to publish the providers email	H:MMam H:MM AM H:MM AM H:MMpm H:MMpm H:MMPM Closed xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx	
Consent to publish Individual Provider Email Address (Y or N) (Publication of Provider Email	Answers the question - Does the provider permit UHC to publish the providers email address in the UHC directory? (Yes or No)	H:MMam H:MM AM H:MMAM H:MMpm H:MMpm H:MM PM H:MMPM Closed	
Consent to publish Individual Provider Email Address (Y or N) (Publication of Provider Email Address will default to No, unless	Answers the question - Does the provider permit UHC to publish the providers email address in the UHC directory? (Yes or No)	H:MMam H:MM AM H:MMAM H:MMpm H:MMpm H:MM PM H:MMPM Closed	
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Consent to publish Individual Provider Email Address (Y or N) (Publication of Provider Email Address will default to No, unless otherwise noted) If this place of service location is accessible by public transportation,	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	H:MMam H:MM AM H:MM AM H:MM pm H:MMpm H:MMPM Closed xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx	Suggested
Consent to publish Individual Provider Email Address (Y or N) (Publication of Provider Email Address will default to No, unless otherwise noted) If this place of service location is accessible by public transportation, please list the types of public	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 Identifies the types of public transportation available accessible for the place of service	H:MMam H:MM AM H:MMAM H:MMpm H:MMpm H:MMPM Closed xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx	Suggested
Consent to publish Individual Provider Email Address (Y or N) (Publication of Provider Email Address will default to No, unless otherwise noted) If this place of service location is accessible by public transportation,	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 Identifies the types of public transportation available accessible for the place of service location	H:MMam H:MM AM H:MMAM H:MMpm H:MMpm H:MMPM Closed xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx	Suggested
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Consent to publish Individual Provider Email Address (Y or N) (Publication of Provider Email Address will default to No, unless otherwise noted) If this place of service location is accessible by public transportation, please list the types of public transportation that are accessible Is this Location Handicap Accessible? (Y or N) 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 If this place of service location offers other services for people with disabilities please list those services Does this Practice Location serve	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 Identifies the types of public transportation available accessible for the place of service location Indiana Medicaid Answers the question: does the practice location meet ADA Accessibility criteria? (Yes or No) Indiana Medicaid Suggested Handicap accessibility is required for Ohio and Texas Medicaid List all areas of handicap accessibility. Types may include: *T = EXAM TABLE/SCALE/CHAIR *G = GURNEYS & STRETCHERS *PL = PORTABLE JIFTS *RE = RADIOLOGIC EQUIPMENT *S = SINGAGE & DOCUMENTS Indiana Medicaid List additional services offered to people with disabilities.	H:MMam H:MM AM H:MM AM H:MMpm H:MMpm H:MMPM Closed xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx	Suggested Suggested Required (if applicable) Suggested
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Consent to publish Individual Provider Email Address (Y or N) (Publication of Provider Email Address will default to No, unless otherwise noted) If this place of service location is accessible by public transportation, please list the types of public transportation that are accessible Is this Location Handicap Accessible? (Y or N) 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 If this place of service location offers other services for people with disabilities please list those services Does this Practice Location serve	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 Identifies the types of public transportation available accessible for the place of service location Indiana Medicaid Answers the question: does the practice location meet ADA Accessibility criteria? (Yes or No) Indiana Medicaid Suggested Handicap accessibility is required for Ohio and Texas Medicaid 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 List additional services offered to people with disabilities. Indiana Medicaid	H:MMam H:MM AM H:MM AM H:MMpm H:MMpm H:MMPM Closed xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx	Suggested Suggested Required (if applicable) Suggested Suggested

Languages Spoken at this Location	Languages other than English fluently spoken by the provider or staff; comma-separated if	Open text	Required
	fluent in multiple languages		
(English will be listed as default,			
unless otherwise noted)	Enter "MTI" if location offers translation and interpretive language services via a third party		
	vendor.		
	Definition of Language Services Vendor:		
	- telephone/video interpretation services		
	- trained professional interpreters		
	- bilingual staff interpreters		
	- family members as interpreters		
Languages Chales Du	- printed materials in multiple languages	Ones test	Suggested
Languages Spoken By	Indicate if the language other than English is fluent by the provider, staff, interpreter or a combination of those	Open text	Suggested
P = Provider	combination of those		
S = Staff	If MTI vendor code used for the language, then this value should be "I" or "Interpreter"		
B = Both Provider & Staff	in Prinvendor Code asea for the language, then this value should be 1 or interpreter		
I = Skilled Interpreter	(Default to provider if not specified)		
X = Interpreter & Staff	(/		
Y=Interpreter and Physician			
A=All			
U=Unknown			
Languages Written at this Location	Languages other than English fluently written by the provider or staff; comma-separated if	Open text	Suggested
	fluent in multiple languages		
	Enter "MTI" if location offers translation and interpretive language services via a third party		1
	vendor.		1
			1
	Definition of Language Services Vendor:		1
	- telephone/video interpretation services		1
	- trained professional interpreters		1
	- bilingual staff interpreters		1
	- family members as interpreters		1
	- printed materials in multiple languages		
Language Written By	Indicate if the language other than English is fluent by the provider, staff, interpreter or a	Open text	Suggested
L	combination of those		1
P = Provider			
S = Staff	If MTI vendor code used for the language, then this value should be "I" or "Interpreter"		
B = Both Provider & Staff			
I = Skilled Interpreter			
X = Interpreter & Staff			
Y=Interpreter and Physician			
A=All			
U=Unknown	I will a state of the state of	0	Suggested
Telehealth Services Type	Identifies the type of telehealth services the provider offers the patients at this location	Open text	ouggested
	identifies the type of teterleatin services the provider oriers the patients at this tocation	Open text	oussessed
A = Audio only	identifies the type of teterleadin services the provider offers the patients at this location	Open text	Suggested
A = Audio only V= Audio/Video	identifies the type of teterleatin services the provider others the patients at this location	Орен сех	Suggested
A = Audio only V= Audio/Video R = Remote patient monitoring	identifies the type of teterleatin services the provider offers the patients at this location	Open text	SUBSECTION
A = Audio only V= Audio/Video R = Remote patient monitoring device	identifies the type of teterleatur services the provider offers the patients at this location	Open text	Suggested
A = Audio only V= Audio/Video R = Remote patient monitoring device O = Online adaptive interviews	identifies the type of teterleatur services the provider offers the patients at this location	Open text	Suggested
A = Audio only V= Audio/Video R = Remote patient monitoring device O = Online adaptive interviews N= Neither/Not Offered	identifies the type of teterleatur services the provider oriers the patients at this location	Open text	Suggested
A = Audio only V= Audio/Video R = Remote patient monitoring device O = Online adaptive interviews N= Neither/Not Offered "Blank" = Neither/Not Offered			
A = Audio only V= Audio/Video R = Remote patient monitoring device O = Online adaptive interviews N= Neither/Not Offered	Describes if the telehealth visit is available to the patients within 15 minutes of the	Open text	Suggested
A = Audio only V= Audio/Video R = Remote patient monitoring device O = Online adaptive interviews N= Neither/Not Offered "Blank" = Neither/Not Offered			
A = Audio only V= Audio/Video R = Remote patient monitoring device O = Online adaptive interviews N= Neither/Not Offered "Blank" = Neither/Not Offered	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		
A = Audio only V= Audio/Video R = Remote patient monitoring device O = Online adaptive interviews N= Neither/Not Offered "Blank" = Neither/Not Offered 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		
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A = Audio only V= Audio/Video R = Remote patient monitoring device O = Online adaptive interviews N= Neither/Not Offered Telehealth Scheduling Type O= On-Demand S = Scheduled	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		
A = Audio only V= Audio/Video R = Remote patient monitoring device O = Online adaptive interviews N= Neither/Not Offered "Blank" = Neither/Not Offered Telehealth Scheduling Type O= On-Demand S = Scheduled B = Both On Demand & Scheduled "Blank" = default to unknown	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).	Open text	Suggested
A = Audio only V= Audio/Video R = Remote patient monitoring device O = Online adaptive interviews N= Neither/Not Offered Telehealth Scheduling Type O= On-Demand S = Scheduled B = Both On Demand & Scheduled "Blank" = default to unknown Telehealth Services Availability	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). Defines if the provider offers telehealth services for new patients, existing patients or both	Open text	
A = Audio only V= Audio/Video R = Remote patient monitoring device O = Online adaptive interviews N= Neither/Not Offered "Blank" = Neither/Not Offered Telehealth Scheduling Type O= On-Demand S = Scheduled B = Both On Demand & Scheduled "Blank" = default to unknown	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).	Open text	Suggested
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A = Audio only V= Audio/Video R = Remote patient monitoring device O = Online adaptive interviews N= Neither/Not Offered Telehealth Scheduling Type O= On-Demand S = Scheduled B = Both On Demand & Scheduled "Blank" = default to unknown Telehealth Services Availability	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). Defines if the provider offers telehealth services for new patients, existing patients or both new and existing patients. N = New Patients only	Open text	Suggested
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A = Audio only V= Audio/Video R = Remote patient monitoring device O = Online adaptive interviews N= Neither/Not Offered Telehealth Scheduling Type O= On-Demand S = Scheduled B = Both On Demand & Scheduled "Blank" = default to unknown Telehealth Services Availability	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). 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	Open text	Suggested
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A = Audio only V= Audio/Video R = Remote patient monitoring device O = Online adaptive interviews N= Neither/Not Offered "Blank" = Neither/Not Offered Telehealth Scheduling Type O= On-Demand S = Scheduled B = Both On Demand & Scheduled "Blank" = default to unknown Telehealth Services Availability Patient Indicator Practice Web Address (URL)	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). 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 Website URL specific to the practice location	Open text	Suggested Suggested Suggested
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A = Audio only V= Audio/Video R = Remote patient monitoring device O = Online adaptive interviews N= Neither/Not Offered "Blank" = Neither/Not Offered Telehealth Scheduling Type O= On-Demand S = Scheduled B = Both On Demand & Scheduled "Blank" = default to unknown Telehealth Services Availability Patient Indicator Practice Web Address (URL) Practice Web Address (URL) Type: T = Capable of accessing URL to schedule in-person appointments I = Capable of accessing URL to schedule in-person appointments S = Single Sign-On portal where patients login to interface with the	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). 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 Website URL specific to the practice location 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	Open text Open text T I S	Suggested Suggested Suggested
A = Audio only V= Audio/Video R = Remote patient monitoring device O = Online adaptive interviews N= Neither/Not Offered "Blank" = Neither/Not Offered Telehealth Scheduling Type O= On-Demand S = Scheduled B = Both On Demand & Scheduled "Blank" = default to unknown Telehealth Services Availability Patient Indicator Practice Web Address (URL) 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	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). 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 Website URL specific to the practice location 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	Open text Open text T I S	Suggested Suggested Suggested
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A = Audio only V= Audio/Video R = Remote patient monitoring device O = Online adaptive interviews N= Neither/Not Offered "Blank" = Neither/Not Offered Telehealth Scheduling Type O= On-Demand S = Scheduled B = Both On Demand & Scheduled "Blank" = default to unknown Telehealth Services Availability Patient Indicator Practice Web Address (URL) Type: T = Capable of accessing URL to schedule telehealth appointments I = Capable of accessing URL to schedule telehealth appointments S = Single Sign-On portal where patients login to interface with the provider office "Blank" indicates the practice web	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). 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 Website URL specific to the practice location 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	Open text Open text T I S	Suggested Suggested Suggested
A = Audio only V= Audio/Video R = Remote patient monitoring device O = Online adaptive interviews N= Neither/Not Offered "Blank" = Neither/Not Offered Telehealth Scheduling Type O= On-Demand S = Scheduled B = Both On Demand & Scheduled "Blank" = default to unknown Telehealth Services Availability Patient Indicator 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	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). 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 Website URL specific to the practice location 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	Open text Open text T I S	Suggested Suggested Suggested
A = Audio only V= Audio/Video R = Remote patient monitoring device O = Online adaptive interviews N= Neither/Not Offered "Blank" = Neither/Not Offered Telehealth Scheduling Type O= On-Demand S = Scheduled B = Both On Demand & Scheduled "Blank" = default to unknown Telehealth Services Availability Patient Indicator 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	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). 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 Website URL specific to the practice location 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	Open text Open text T I S	Suggested Suggested Suggested
A = Audio only V= Audio/Video R = Remote patient monitoring device O = Online adaptive interviews N= Neither/Not Offered "Blank" = Neither/Not Offered Telehealth Scheduling Type O= On-Demand S = Scheduled B = Both On Demand & Scheduled "Blank" = default to unknown Telehealth Services Availability Patient Indicator 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	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). 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 Website URL specific to the practice location 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	Open text Open text T I S	Suggested Suggested Suggested
A = Audio only V= Audio/Video R = Remote patient monitoring device O = Online adaptive interviews N= Neither/Not Offered "Blank" = Neither/Not Offered Telehealth Scheduling Type O= On-Demand S = Scheduled B = Both On Demand & Scheduled "Blank" = default to unknown Telehealth Services Availability Patient Indicator Practice Web Address (URL) 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	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). 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 Website URL specific to the practice location 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	Open text Open text T I S	Suggested Suggested Suggested

Contact Email Address	Email address of the location/group contact listed on the file	Open text	Suggested
	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.		
Contact Time (of a office manager	Title of the location/group contact listed on the file	Onentest	Custostad
Contact Type (e.g. office manager,	Thite of the tocation/group contact tisted on the fite	Open text	Suggested
billing, credentialing, etc.)			
Contact Phone	Phone # of the location/group contact listed on the file	10 numeric digits with or without hyphens/parenthesis	Suggested
	For Hospital Based Providers, the phone or should be the one where the provider can be		
	contacted e.g. medical group administration. Typically not the actual HBP provider's		
	phone or fax		
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	Designates cultural competency training completed by the provider		Suggested
Training		SCC = Chronic Conditions/Clinical Care/Specialized Interest	
Tulling		300 - Ontonic Conditions/Clinical Care/Specialized Interest	
		CII - Cultural Humilita	
		CH = Cultural Humility	
		LIT = Language, Interpretation, and Translation	
	1		
		LGB = LGBTQ+ Communities	
		PWD = People with Disabilities	
	1		
		SDH = Social Determinants of Health (SDoH)	
Effective/Completion Date of	Date cultural competency training was completed	MM/DD/YYYY	Suggested
Cultural Competency Training		MM/D/YYYY	
a.a. competency rianning		M/D/YYYY	
		M/DD/YYYY	
		MM-DD-YYYY	
		MM-D-YYYY	
		M-D-YYYY	
		M-DD-YYYY	
Expiration Date of Cultural	Date cultural competency training certification expires	MM/DD/YYYY	Suggested
Competency Training		MM/D/YYYY	
		M/D/YYYY	
		M/DD/YYYY	
		MM-DD-YYYY	
		MM-D-YYYY	
		M-D-YYYY	
		M-DD-YYYY	
Ecceptial Community Provider (ECD):	Designate if the provider serves predominantly low-income, medically underserved	Y=Yes, is a designated ECP provider	Suggested
			Suggested
Provider serves predominantly low-	individuals	N=No, is not a designated ECP provider	
income, medically underserved			
individuals			
Medicaid Only			
Medicaid Number for this Provider at	Required if participating with Medicaid Line of Business; list the Provider Medicaid ID by	#######	Required (if applicable)
this location	location		
Required if group/provider			
participates in Medicaid Only			
Medicaid: State Issuing	Required if participating with Medicaid Line of Business; State in which the provider	State abbreviation	Required (if applicable)
ricalisatar state issumig	Medicaid ID is active	Open text	nequires (in applicable)
Medicare Number for this Provider	Provider Medicare ID		Suggested
Predicate Number for this Provider	r rovider riedicale ID	Open text	Suggested
Drimon Drootlein & Original	The maintain and talks are said and bright are state and decreased and the said and	Onentest	Demuired
Primary Practicing Specialty	The primary specialty practiced by the provider and deemed qualified by the Delegate for	Open text	Required
	the Tax ID.		
Board Certification Status	Identifies the provider's certification status by ABMS or an approved Board as listed in the		Required (if applicable)
	UHC Credentialing Plan	X= Not Applicable	
	4		
		MM/DD/YYYY	Required (if applicable)
Board Certification Effective Date	The effective date the provider became certified by ABMS or approved acceptable Board		1
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/D/YYYY	
Board Certification Effective Date		MM/D/YYYY M/D/YYYY	
Board Certification Effective Date			
Board Certification Effective Date		M/D/YYYY M/DD/YYYY	
Board Certification Effective Date		M/D/YYYY M/DD/YYYY MM-DD-YYYY	
Board Certification Effective Date		M/D/YYYY M/DD/YYYY MM-DD-YYYY MM-D-YYYY	
Board Certification Effective Date		M/D/YYYY M/DD/YYYY MM-D-YYYY MM-D-YYYY M-D-YYYY	
	as listed in the UHC Credentialing Plan	M/D/YYYY M/DD/YYYY MM-D-YYYY MM-D-YYYY M-D-YYYY M-D-YYYY M-D-YYYY	
Board Certification Effective Date	as listed in the UHC Credentialing Plan The date the provider's certification by ABMS, or approved acceptable Board as listed in	M/D/YYYY M/DD/YYYY MM-DD-YYYY MM-D-YYYY M-D-YYYY M-D-YYYY M-DD-YYYY MM/DD/YYYY	Required (if applicable)
	as listed in the UHC Credentialing Plan	M/D/YYYY M/DD/YYYY MM-D-YYYY MM-D-YYYY M-D-YYYY M-D-YYYY M-D-YYYY MM/D/YYYY MM/D/YYYY	Required (if applicable)
	as listed in the UHC Credentialing Plan The date the provider's certification by ABMS, or approved acceptable Board as listed in	M/D/YYYY M/DD/YYYY MM-D-YYYY MM-D-YYYY M-D-YYYY M-D-YYYY MM/D/YYYY MM/D/YYYY M/D/YYYY	Required (if applicable)
	as listed in the UHC Credentialing Plan The date the provider's certification by ABMS, or approved acceptable Board as listed in	M/D/YYYY M/DD/YYYY MM-D-YYYY MM-D-YYYY M-D-YYYY M-D-YYYY M-D-YYYY MM/D/YYYY MM/D/YYYY	Required (if applicable)
	as listed in the UHC Credentialing Plan The date the provider's certification by ABMS, or approved acceptable Board as listed in	M/D/YYYY M/DD/YYYY MM-D-YYYY MM-D-YYYY M-D-YYYY M-D-YYYY MM/D/YYYY MM/D/YYYY M/D/YYYY	Required (if applicable)
	as listed in the UHC Credentialing Plan The date the provider's certification by ABMS, or approved acceptable Board as listed in	M/D/YYYY M/DD/YYYY MM-D-YYYY MM-D-YYYY M-D-YYYY M-D-YYYY MM/DD/YYYY MM/DD/YYYY M/DD/YYYY M/DD/YYYY M/DD/YYYY	Required (if applicable)
	as listed in the UHC Credentialing Plan The date the provider's certification by ABMS, or approved acceptable Board as listed in	M/D/YYYY M/DD/YYYY MM-D-YYYY M-D-YYYY M-D-YYYY M-D-YYYY M-DD-YYYY MM/DD/YYYY MM/D/YYYY M/DD/YYYY MM-D-YYYY	Required (if applicable)
	as listed in the UHC Credentialing Plan The date the provider's certification by ABMS, or approved acceptable Board as listed in	M/D/YYYY M/DD/YYYY MM-D-YYYY MM-D-YYYY M-D-YYYY M-D-YYYY MM/D/YYYY MM/D/YYYY M/DD/YYYY M/DD/YYYY M/DD-YYYY MM-D-YYYY MM-D-YYYY M-D-YYYY M-D-YYYY M-D-YYYY	Required (if applicable)
Board Certification Expiration Date	as listed in the UHC Credentialing Plan The date the provider's certification by ABMS, or approved acceptable Board as listed in the UHC Credentialing Plan, expires	M/D/YYYY M/DD/YYYY MM-D-YYYY MM-D-YYYY M-D-YYYY M-DD-YYYY MM/DD/YYYY MM/DD/YYYY MM-DD-YYYY MM-D-YYYY MM-D-YYYY M-D-YYYY M-D-YYYY M-D-YYYY M-D-YYYY M-D-YYYY M-D-YYYY	
Board Certification Expiration Date Accepting New & Existing Patients for	as listed in the UHC Credentialing Plan The date the provider's certification by ABMS, or approved acceptable Board as listed in the UHC Credentialing Plan, expires Answers the question: is this provider accepting new and existing patients by specialty for	M/D/YYYY M/DD/YYYY MM-D-YYYY MM-D-YYYY M-D-YYYY M-D-YYYY MM/D/YYYY MM/D/YYYY MM/D/YYYY MM-DD-YYYY MM-D-YYYY MM-D-YYYY MM-D-YYYY M-D-YYYY M-D-YYYY M-D-YYYY M-D-YYYY Yes	Required (if applicable) Required
Board Certification Expiration Date Accepting New & Existing Patients for All Lines of Business; Refer to	as listed in the UHC Credentialing Plan The date the provider's certification by ABMS, or approved acceptable Board as listed in the UHC Credentialing Plan, expires 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	M/D/YYYY M/DD/YYYY MM-DD-YYYY MM-D-YYYY M-D-YYYY M-DD-YYYY MM/DD/YYY MM/DD/YYY M/DD/YYY M/DD/YYYY M/DD/YYYY M/DD/YYYY M/DD/YYYY M/DD-YYYY MM-D-YYYY M-D-YYYY M-DD-YYYY	
Board Certification Expiration Date Accepting New & Existing Patients for All Lines of Business; Refer to columns DD through DG if status	as listed in the UHC Credentialing Plan The date the provider's certification by ABMS, or approved acceptable Board as listed in the UHC Credentialing Plan, expires 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	M/D/YYYY M/DD/YYYY MM-D-YYYY MM-D-YYYY M-D-YYYY M-D-YYYY MM/D/YYYY MM/D/YYYY M/DD/YYYY MM-D-YYYY MM-D-YYYY MM-D-YYYY M-D-YYYY Yes No Y	
Board Certification Expiration Date Accepting New & Existing Patients for All Lines of Business; Refer to	as listed in the UHC Credentialing Plan The date the provider's certification by ABMS, or approved acceptable Board as listed in the UHC Credentialing Plan, expires 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	M/D/YYYY M/DD/YYYY MM-DD-YYYY MM-D-YYYY M-D-YYYY M-DD-YYYY MM/DD/YYY MM/DD/YYY M/DD/YYY M/DD/YYYY M/DD/YYYY M/DD/YYYY M/DD/YYYY M/DD/YYYY MM-D-YYYY M-D-YYYY M-DD-YYYY	
Board Certification Expiration Date Accepting New & Existing Patients for All Lines of Business; Refer to columns DD through DG if status	as listed in the UHC Credentialing Plan The date the provider's certification by ABMS, or approved acceptable Board as listed in the UHC Credentialing Plan, expires 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	M/D/YYYY M/DD/YYYY MM-D-YYYY MM-D-YYYY M-D-YYYY M-D-YYYY MM/D/YYYY MM/D/YYYY M/DD/YYYY MM-D-YYYY MM-D-YYYY MM-D-YYYY M-D-YYYY Yes No Y	

		-	
Secondary Practicing Specialty	The secondary specialty practiced by the provider and deemed qualified by the Delegate for the Tax ID.	Open text	Required (if applicable)
Board Certification Status 2	Identifies the provider's certification status by ABMS or an approved Board as listed in the UHC Credentialing Plan	C= 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/YYY MM/D/YYY M/D/YYY M/D/YYY MM-DD-YYYY MM-D-YYYY M-D-YYYY M-D-YYYY M-D-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/DD/YYYY M/DD-YYYY MM-DD-YYYY MM-D-YYYY M-D-YYYY M-D-YYYY M-D-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: https://www.uhcprovider.com/content/dam/provider/docs/public/ion/aoe-indicators.pdf	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 Hospital Based Provider (HBP) is confirmation the provider practices exclusively in an inpatient setting and provide care for organization members only because members are directed to the hospital or another inpatient setting. Hospital Based Providers include: Anesthesiology, Assistant Surgeon, Emergency Medicine, Hospitalist, Neonatology, Pathology, and Radiology. Hospitalists are physicians who specialize in the care of members in an acute inpatient setting (acute care hospitals and skilled nursing facilities). A hospitalist oversees the member's inpatient admission and coordinates all inpatient care.	PCP, Specialist, Hospital-Base Provider or Locum Tenen	Required
Advanced Practice Clinicians (aka Midtevels) 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	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/DD/YYYY M/DD/YYYY MM-DD-YYYY MM-D-YYYY M-D-YYYY M-D-YYYY M-D-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 M/D/YYYY M/DD/YYYY MM-DD-YYYY MM-DD-YYYY MM-D-YYYY M-D-YYYY M-D-YYYY M-D-YYYY	Suggested

Indiana Medicaid Providers: the registration number or notation of N/A is required Name of Admitting Hospital Nam Affiliation(s) or Covering beha Group/Provider name Requ	me of Hospital or covering provider/group name that will admit members on your		Required, if applicable
registration number or notation of N/A is required Name of Admitting Hospital Nam Affiliation(s) or Covering beha Group/Provider name Requ		Open Text	Required, if applicable
NÄ is required Name of Admitting Hospital Affiliation(s) or Covering Group/Provider name Requ For a		Open Text	Required, if applicable
Name of Admitting Hospital Nam Affiliation(s) or Covering beha Group/Provider name Requ For a		Open Text	Required, if applicable
Affiliation(s) or Covering Group/Provider name Requ For a		Open Text	Required, if applicable
Group/Provider name Requ For a	iau		
Requ			
For a	quired for all MD's and DO's, except Dermatologists. Also required for NP's and PA's	1	
		1	
is rec	all Hospital Based Provider (Physician and Mid-level) the name of the Hospital facility	1	
	equired.	1	
Admitting Hospital Affiliation Status Ident	ntify the status of the providers Hospital Privileges (not applicable for covering	AC = Active	Required (if applicable)
	,	ACA = Assistant Attending	nequired (if applicable)
		ACT =C81 Active Admitting	
Requ		ADJ =Adjunct Staff	
		ADM = Admitting	
		AFF = Affiliate ASC = Associate	
		ATA = Assistant Adjunct	
		ATT = Attending	
		CLP = Clinical Privileges	
		CN = Consulting Admitting	
		CON = Courton	
		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 = Temporary Admitting; UNK = Unknown	
Medical School Name			Suggested
			Suggested
		MM/D/YYYY	
		M/D/YYYY M/DD/YYYY	
		MM-DD-YYYY	
		MM-D-YYYY	
		M-D-YYYY	
		M-DD-YYYY	
		Open text with exception noted below	Required, if applicable
locat	ation and maximum patient age the provider can treat at this location	Indiana Medicaid PMP's must select from the following ranges;	
Regu		please note the ranges marked with an asterisk are not	
,-		available to Internal Medicine & OB/GYN practitioners:	
		1	
		None*	
		0 - 2 years * 0 - 12 years*	
		0 - 12 years* 0 - 17 years*	
		0 - 20 years *	
		3+ years *	
		13+ years	
		13 - 17 years 13 - 20 years	
		13 - 20 years 17+ years	
		21+ years	
		65+ years	
		Yes No	Required (if applicable)
tocat		Y	
Requ		N	
Scope of Practice Ident			Required, if applicable
Demoisor de colonie		one designation:	
*	GYN practitioner offering only OB services, indicate "O" GYN offering services to all women (pregnant and non-pregnant), indicate "B"	B = All Women (OB/GYN)	
-		B = All Women (OB/GYN) O = OB Only (OB/GYN)	
-		O = OB (Family Practitioners)	
I FP DI		N/A = Family Practitioner does not provide OB care	
FP рі			
Delivery Privileges or Covering Ident		Open Text	Required, if applicable
Delivery Privileges or Covering Ident	ntifies hospital delivery privileges or covering arrangements for Indiana Medicaid /GYNs and Family Practitioners whose scope of practice includes obstetrics	Open Text	Required, if applicable
Delivery Privileges or Covering Ident		Open Text	Required, if applicable
Delivery Privileges or Covering Ident Arrangements OB/G		Open Text	Required, if applicable

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Product in vito closed on who closed on who complete properties tables to establish patients all strategies in the discharged for applications of the complete products and earthing patients for Medical and members. Out O - Open Accepting New A Bistang Patients - Secretary New A Bistang Patients - Secretary New A Bistang Patients - Applicability in groups of the provider accepting new patient obtains to establish patients all significant and all significant an
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EDD, EdS. RPO, HIS, LPC, LPM, LVN, MA, MA, MA, MA, MA, MA, MA, MA, MA, MA
MSN, MSW, MTH, ND, "NON", "NON EDD", NP, OD, OTR, PA, PHA, PHD, PSY, PT, RD, RN, RNA, RRT, RSW SLP, VNA Primary Practicing Specialty The primary specialty practiced by the provider and deemed qualified by the Delegate Original Credentialing Committee Date Date on which the group first credentialed/approved the provider MM/DD/YYY MM-DYYY MM-DYYYY MM-DYYY MM-DYYYY MM-DYYYY MM-DYYY MM-
Primary Practicing Specialty The primary specialty practiced by the provider and deemed qualified by the Delegate Original Credentialing Committee Date Date on which the group first credentialed/approved the provider MM/DD/YYY MM-DD-YYYY MM-DD-YYYY MM-DD-YYYY MD-YYYY MD
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M-D-YYYY M-DD-YYYY M-DD-
Latest Re-Appointment/ Re- Credentialing Committee Approval 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/YYY MM/DD/YYY MM/DD/YYY MM-D-YYYY MM-D-YYYY M-D-YYYY M-D-YYY
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Credentialing Committee Approval paper or approval. The most recent recredentialing events within 30 days of credentialing committee's Approval. MM/D/YYY M/D/YYY MM-D-YYYY MM-D
Date approval. M/D/YYY M/DD/YYY MM-D-YYYY M-D-YYYY M-D-YYY M-D-YYYY M-D-YYYY M-D-YYY M-D-YYY M-D-YYY M-D-YYY M-D-YYYY M-D-YYY M-D-YYY M-D-YYY M-D-YYY M-D-YYY M-D-YYY M-D-YYY
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MM-DD-YYYY MM-D-YYYY M-D-YYYY M-D-YYYY State State of the primary practice location Open text Suggested Updates Tab Change Type R=Remove Identifies if the transaction being requested is to add or remove the demographic reported Remove Required
MM-DD-YYYY MM-D-YYYY M-D-YYYY M-D-YYYY State State of the primary practice location Open text Suggested Updates Tab Change Type R=Remove Identifies if the transaction being requested is to add or remove the demographic reported Remove Required
MM-D-YYYY M-D-YYYY M-D-YYYY State State of the primary practice location Open text Suggested Updates Tab Change Type R-Remove Identifies if the transaction being requested is to add or remove the demographic reported Remove Revenue. MM-D-YYYY M-D-YYYY M-D-YYY M-D-YYYY M-D-YYY M-D-YYYY M-D-YYY M-D-Y-YY M-D-Y-YY M-D-Y-YY M-D-Y-YY M-D-YYY M-D-Y-YY M-D-Y-Y M-D-Y-YY M-D-Y-Y M-D-Y
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State State of the primary practice location Open text Suggested Updates Tab Change Type R=Remove Identifies if the transaction being requested is to add or remove the demographic reported Remove Revenue
State State of the primary practice location Open text Suggested Updates Tab Change Type R=Remove Identifies if the transaction being requested is to add or remove the demographic reported Remove Revenue
Updates Tab Change Type Identifies if the transaction being requested is to add or remove the demographic reported Remove Rendered Remove Report Remove Rendered Rende
Change Type Identifies if the transaction being requested is to add or remove the demographic reported R=Remove Required
R=Remove Remove
R=Remove Remove
A Add
A=Add A
Add

Effective Date of Change	Identifies the date the demographic change occurred	MM/DD/YYYY	Required
		MM/D/YYYY	
		M/D/YYYY	
		M/DD/YYYY	
		MM-DD-YYYY	
		MM-D-YYYY	
		M-D-YYYY	
		M-DD-YYYY	
	Termination tab (ful	l term/tin term)	
Termination date	Date in which provider is no longer at the group/practice	MM/DD/YYYY	Required
		MM/D/YYYY	
		M/D/YYYY	
		M/DD/YYYY	
		MM-DD-YYYY	
		MM-D-YYYY	
		M-D-YYYY	
		M-DD-YYYY	
Reason for termination	Reason provider is no longer with the group or tin listed for termination.	44 - Deceased	Required
		45 - Retired	
	UHC will default to Provider Left Group if omitted in the submission	46 - Left Group	
		74 - Involuntary for Loss of License, License restriction, state	
		or federal sanction	
Provider Reassignment or	Identifies the provider the members should be reassigned to.	Open text	Suggested
Recommendation			