



Additional State and Federal Credentialing Requirements

The information contained in the attached amendments supplements the detailed credentialing criteria identified in the UnitedHealthcare Credentialing Plan.

Table of contents

Contents

Alabama.....	4
Alaska.....	5
Arizona.....	6-7
Arkansas.....	8
California.....	9
Colorado.....	10
Connecticut.....	11
Delaware.....	12
Florida.....	13-14
Georgia.....	15
Hawaii.....	16
Idaho.....	17
Illinois.....	18
Indiana.....	19
Iowa.....	20
Kansas.....	21
Kentucky.....	22
Louisiana.....	23
Maine.....	24
Maryland.....	25-26
Massachusetts.....	27
Michigan.....	28
Minnesota.....	29
Mississippi.....	30-31
Missouri.....	32-33
Montana.....	34
Nebraska.....	35

Nevada	36
New Hampshire.....	37
New Jersey.....	38-39
New Mexico.....	40-41
New York.....	42
North Carolina	43-44
North Dakota.....	45
Ohio.....	46-47
Oklahoma	48
Oregon	49
Pennsylvania	50-51
Puerto Rico	52
Rhode Island	53
South Carolina.....	54
South Dakota	55
Tennessee	56-57
Texas.....	58-60
Utah.....	61
Vermont.....	62
Virgin Islands (U.S.)	63
Virginia.....	64
Washington D.C.	65
Washington	66
West Virginia	67
Wisconsin	68
Wyoming.....	69
Federal Requirements for Medicare Participation	70

Rev 07/2011, 08/2011, 03/2012, 11/2012, 11/2013, 5/2014, 10/2014, 3/2015, 08/2015,12/2015, 03/2016, 06/2016,11/2016, 2/2017, 6/2017, 11/2017, 01/2018, 07/2018, 10/2018, 01/2019

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Alabama

Alabama (AL) Administrative Code (section 420-5-6-.11) requires Health Maintenance Organizations (HMOs) to:

1. Recredential licensed independent practitioners every two years.* (On June 24, 2003, UnitedHealthcare of Alabama was issued an exception to the Alabama State Board of Health Chapter 420-5-6.11.4. (c) allowing the recredentialing of providers every three years.)
2. Update expired professional license, drug enforcement agency, controlled substance certificate and professional liability insurance for licensed independent practitioners upon expiration.
3. Have a medical director with a current license to practice medicine granted by the Medical Licensure Commission of Alabama.
4. An AL HMO may delegate credentialing, with oversight. Delegation must be approved by the AL Department of Public Health.

AL Insurance Code (section 27-56-4)

HMOs and Preferred Provider Organizations may not require an eye care provider (optometrist and ophthalmologists) to hold hospital privileges as a condition of participation in or receiving payment from the policy, plan, or contract.

Alaska

No additional credentialing requirements.

Alaska UnitedHealthcare Community Plan Requirements

Federal database checks on Practitioners and Facilities of the Office of Inspector General List of Excluded Individuals/Entities (OIG/LEIE) and the General Services Administration's System for Awards Management (GSA/SAM) (the successor to the Excluded Parties List System (EPLS)) prior to credentialing/recredentialing decision.

Additional query of ALASKA MEDICAL ASSISTANCE EXCLUDED PROVIDER LIST is required for Practitioners and Facilities: <http://dhss.alaska.gov/Commissioner/Pages/ProgramIntegrity/default.aspx>

Contracted providers need to be registered with the State (DHHS) as an approved services provider consistent with screening/enrollment requirements under provision 42 CFR 438.608(b). Medicaid enrollment required for network participation, but not considered a credentialing decision element as managed through Provider Contract & Data Management (PCDM) operations.

Arizona

Health Maintenance Organizations (HMOs) are required to review the performance of and recredential contracted free-standing urgent care centers at least once every two years. (ARS 20-1077).

Effective December 31, 2018:

Credentialing; loading; timeliness; exceptions A.R.S. 20-3403

1. Health insurer shall conclude the process of credentialing and loading the applicants information into their billing system within one hundred calendar days after the date the insurer receives a complete application.
2. Health Insurer shall provider written or electronic notice of an approval or denial of a credentialing application to an applicant within seven calendar days after the conclusion of the credentialing process.
3. Health insurer is not responsible for compliance with the above timelines if the applicant is subject to delegated credentialing. Health insurer shall conclude the loading process for the applicant within ten calendar days after the health insurer receives a roster of demographic changes related to newly credentialed, terminated or suspended participating providers.

Acknowledgement of receipt of an application; notification of incomplete applications A.R.S. 20-3404

1. Health insurer shall promptly review and provide written or electronic acknowledgement to an applicant within seven days after the health insurer's receipt of the applicant's application.
2. Health insurer shall notify the applicant in writing or by electronic means that an application is incomplete within seven calendar days after the date the health insurer received the application. Health insurer shall include detailed list of items required to complete the application.
3. Health insurer may deem the application withdrawn if applicant does not provide complete application after thirty calendar days if the request for information.
4. Health insurer will send the applicant a proposed contract that is complete and ready for execution upon receipt of complete application.
5. Health insurer that participates in a health insurer credentialing alliance is deemed to be in compliance with this section, A.R.S. 20-3404.

Arizona UnitedHealthcare Community Plan Requirements^{1,2}

UnitedHealthcare Community Plan participates with the Arizona Association of Health Plans (AzAHP) credentialing alliance³ which provides for

- One common application;
- One common verification;
- One common recredential date;
- One common site visit at the time of initial credentialing for primary care physicians (PCPs) and obstetricians and gynecologists (OB/GYNs)

Arizona Community Plan requirements include:

1. Site visits at the time of initial credentialing for primary care physicians (PCPs) and obstetricians and gynecologists (OB/GYNs).

¹ Requirements of the State Medicaid Contract.

² Chapter 900, Policy 950 of Arizona Health Care Cost Containment System (AHCCCS)

³ Credentialing delegates are not required to use the Alliance

2. Practitioners and Facilities to be screened for Medicare/Medicaid exclusions from additional sources including the Office of the Inspector General List of Excluded Individuals and Entities (OIG-LEIE) and General Services Administration System for Awards Management (GSA-SAM) (the successor to the Excluded Parties List System (EPLS)).
3. Must have policies and procedures to address granting of temporary or provisional credentials when it is in the best interest of members that providers be available to provide care prior to completion of the entire credentialing process. [Temporary or provisional credentialing is intended to increase the available network of providers in medically underserved areas, whether rural or urban. This includes providers in a Federally Qualified Health Center (FQHC) and hospital-employed physicians. Contractor shall have 14 days from receipt of a complete application, accompanied by minimum documents identified in initial credentialing.
4. Timely verification of information must be conducted timely, by evidence of approval or denial of a provider within 90 days of a receipt of complete application. Inclusion of information from quality improvement activities at the time of recredentialing.
5. Claims payment system load time 90% within 30 calendar days of credentialing approval. Effective date should be no later than the date of the Credentialing Committee decision or the Contract effective date, whichever is later.
6. All Credentialing decisions are reviewed and approved by the Arizona Provider Advisory Committee which is the local credentialing committee. Committee members consist of participating Arizona Medicaid Providers and the Committee is chaired by the Local Medical Director. The local Medical Director(s) may approve initial Credentialing and/or Recredentialing files which have been determined to meet state-specific requirements, or may request additional review by the Arizona Provider Advisory Committee.
7. Credentialing/Recredentialing files may include state-specific information and/or data to be utilized in Credentialing/Recredentialing determinations. This state-specific information and/or data may be established and maintained separately from the criteria described in the UnitedHealthcare Credentialing Plan used to evaluate Credentialing/Recredentialing determinations. State-specific information and/or data are defined in the local health plan credentialing policies,
8. Credentialing of behavioral health residential placement settings that utilize behavioral health technicians and behavioral health paraprofessional staff in accordance with Chapter 900, Policy 950 of the AHCCCS Medical Policy Manual (AMPM)

Arkansas

1. The Arkansas (AR) State Medical Board's Centralized Credentialing Verification Service (ASMB – CCVS) is mandated for primary source verification for credentialing physicians. (Arkansas Code Archive section 17-95-107.) Physicians include M.D., D.O and M.B. only. (Arkansas Code section 17-95-202.) Insurers, Health Maintenance Organizations (HMOs) and managed care organizations are:
 - a) Prohibited from seeking credentialing information from the physician or sources other than the Arkansas State Medical Board that is available from the ASMB-CCVS; and
 - b) Required to collect credentials information from the ASMB-CCVS, as long as the ASMB-CCVS:
 - is an National Committee for Quality Assurance (NCQA) -certified Credentials Verification Organization (CVO);
 - complies with Joint Commission on the Accreditation of Healthcare Organizations (JCAHO). CVO standards;
 - complies with credentialing rules and regulations of the AR Division of Health of the Department of Health and Human Services;
 - maintains evidence of compliance with the standards set forth; and
 - charges fees in compliance with AR law.
2. Health care insurers (including HMOs) are required to make a credentialing decision:
 - a) for providers other than physicians, within 180 days of receiving a completed application; and
 - b) for physicians, within 60 days of receiving a completed application. The 60-day time frame is suspended (or tolled) from the time the health care insurer requests credentialing information from the ASMB-CCV until the time that ASMB-CCV notifies the health care insurer that the file is complete and available for retrieval. (Arkansas Code Archive 23-99-411)
3. Health care insurers (including HMOs) are required:
 - a) to send written acknowledgment of an application from any provider within ten (10) days of receipt.
 - b) to notify applicant in writing within 15 days if application is incomplete.
 - i) notice to include list of items required for application to be complete.
 - ii) if notice is not sent within required time frame, application is deemed to be complete.
 - iii) if requested information is not received within 90 days, application may be treated as abandoned and credentialing may be denied.
 - c) to notify network physicians in writing at least 90 days before the deadline to submit a recredentialing application.
 - i) required to give at least 45 days written notice prior to terminating physician for failure to submit a recredentialing application.
 - ii) if the physician submits the recredentialing application during the 45 day period, the termination shall not take effect.
 - iii) during the 45 day period, insurer prohibited from notifying members or general public that physician will be terminated unless termination is for reason other than failure to recredential. (Arkansas Code Archive 23-99-411 – effective July 22, 2015.)
4. If a credentialed physician changes employment or location, opens an additional location, or joins a new group or clinic, health care insurer may only require submission of the new information as is necessary to continue the physician's credentials, and may not require a new credentialing application.

California

California Health & Safety Code (CA H&SC) 1374.16 requires the establishment of a process for standing referrals to a specialist, to include a process to refer a member with a condition or disease that requires specialist medical care over a prolonged period of time or is life-threatening, degenerative or disabling to a specialist or specialty care center that has expertise in treating the condition or disease.

California Code 28 CCR1300.74.16 (e) establishes the required qualifications of an HIV/AIDS specialist to whom a member is being referred on an extended or standing basis, under the conditions of CA H&SC 1374.16.

In order to comply with this regulation, at the time of credentialing, recredentialing and on an annual basis, we identify appropriately qualified specialists within our network who meet the definition of an HIV/AIDS specialist.

For the purposes of this section an “HIV/AIDS specialist” means a physician who holds a valid, unrevoked and unsuspended certificate to practice medicine in the state of California who meets any one of the following four criteria:

- (1) Is credentialed as an “HIV Specialist” by the American Academy of HIV Medicine; or
- (2) Is board certified, or has earned a Certificate of Added Qualification, in the field of HIV medicine granted by a member board of the American Board of Medical Specialties, should a member board of that organization establish board certification, or a Certificate of Added Qualification, in the field of HIV medicine; or
- (3) Is board certified in the field of infectious diseases by a member board of the American Board of Medical Specialties and meets the following qualifications:
 - (A) In the immediately preceding 12 months has clinically managed medical care to a minimum of 25 patients who are infected with HIV; and
 - (B) In the immediately preceding 12 months has successfully completed a minimum of 15 hours of category 1 continuing medical education in the prevention of HIV infection, combined with diagnosis, treatment, or both, of HIV-infected patients, including a minimum of 5 hours related to antiretroviral therapy per year; or
- (4) Meets the following qualifications:
 - (A) In the immediately preceding 24 months has clinically managed medical care to a minimum of 20 patients who are infected with HIV; and
 - (B) Has completed any of the following:
 1. In the immediately preceding 12 months has obtained board certification or recertification in the field of infectious diseases from a member board of the American Board of Medical Specialties; or
 2. In the immediately preceding 12 months has successfully completed a minimum of 30 hours of category 1 continuing medical education in the prevention of HIV infection, combined with diagnosis, treatment, or both, of HIV-infected patients; or
 3. In the immediately preceding 12 months has successfully completed a minimum of 15 hours of category 1 continuing medical education in the prevention of HIV infection, combined with diagnosis, treatment, or both, of HIV-infected patients and has successfully completed the HIV Medicine Competency Maintenance Examination administered by the American Academy of HIV medicine.

California UnitedHealthcare Community Plan Requirements

Site visits at initial credentialing and recredentialing for primary care physicians (PCPs). Reference UnitedHealthcare Community Plan Facility Site and Medical Record Review Policy.

Additional query of State Medi-Cal Suspended and Ineligible Provider List is required for Practitioners and Facilities:
<http://files.medi-cal.ca.gov/pubsdoco/SandLanding.asp>

Credentialing/Recredentialing must receive National Provider Identifier Number (NPI) information from every network provider, but does not need to verify this information through a primary source.

Inclusion of data from quality improvement activities at the time of recredentialing.

Colorado

Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs) are required to:

1. Accept the Colorado (CO) health care professional Credential Application.
(CO Revised Statutes sect. 25-1-108.7.) Application can be found at 6 CCR 1014-4.
2. HMOs are required to credential and recredential providers as often as necessary, but no less frequently than once every 36 months.

Credentialing/recredentialing requirements: License verification, necessary and appropriate certification and accreditation⁴.

If the HMO contracts with health care professionals affiliated with a delegated entity which conducts credentialing for its personnel, verification shall, at a minimum, take the form of ascertaining that the delegated entity's credentialing and recredentialing process is in compliance with the requirements of the regulation. (6 CCR 1011-2(VIII)(A)).

⁴ Outlined in UnitedHealthcare's Credentialing Plan and NCQA Standards

Connecticut

Managed care organizations are required to credential providers, but there are no specific credentialing criteria identified. (CT Annotated Statutes sect. 38a-478-c (a) (5))

Rev 07/2011, 08/2011, 03/2012, 11/2012, 11/2013, 5/2014, 10/2014, 3/2015, 08/2015, 12/2015, 03/2016, 06/2016, 11/2016, 2/2017, 6/2017, 11/2017, 01/2018, 07/2018, 10/2018, 01/2019

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Delaware

Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs) are required to obtain primary source verification of professional liability coverage⁵ and hospital privileges at initial credentialing and on recredentialing. (Code of DE Regulations 18-1400-1403 sect. 11.2.4)

⁵ A copy of professional liability declaration sheet will serve as evidence of primary source verification.

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Florida

Florida (FL) Annotated Statutes (section 641.495) require Health Maintenance Organizations (HMOs):

1. to designate a medical director licensed in FL; and
2. to maintain a copy of the current medical license for each participating physician. (MD, DO, DC and DPM). (Note: physician defined in FL Annotated Statutes section 6.41.19(12) (a)).

Physicians who choose not to carry malpractice insurance, as allowed by Florida law, are required to submit a copy of UnitedHealthcare's "Physicians Responsibility for Medical Malpractice Agreement," demonstrating that they have met the state requirements.

Florida UnitedHealthcare Community Plan Requirements^{6,7}

Florida UnitedHealthcare Community Plan requirements include:

1. Site visits at initial credentialing and recredentialing for primary care physicians (PCPs) only.

To include the following elements:

- a) Must include evidence that the following documents are posted in the provider's waiting room/reception area: the Agency's statewide consumer call center telephone number, including hours of operation, and a copy of the summary of Florida's Patient's Bill of Rights and Responsibilities, in accordance with s. 381.026, F.S. The provider must have a complete copy of the Florida Patient's Bill of Rights and Responsibilities, available upon request by an enrollee, at each of the provider's offices (Eff 12/01/09)
- b) Each site should be assessed against the Delegate's office site criteria and shall include:
- c) Evidence that the provider's office meets criteria for access for persons with disabilities and that adequate space, supplies, proper sanitation, smoke-free facilities, and proper fire and safety procedures are in place;

Evidence that the provider's medical record keeping practices were assessed.

2. Practitioners and Facilities to be screened for Medicare/Medicaid exclusions from additional sources including the Office of the Inspector General List of Excluded Individuals and Entities (OIG-LEIE) and the General Services Administration System for Awards Management (GSA-SAM) (the successor to the Excluded Parties List System (EPLS)) and the National Plan and Provider Enumeration System (NPPES) and Agency for Health Care Administration (AHCA) Public Record Search online tool.
3. Current Curriculum Vitae or completed credentialing application with a five-year working history must be obtained at both initial credentialing and recredentialing.
4. Only board certified pediatricians or family physicians may be contracted as primary care physicians for the Florida Healthy Kids product.
5. Verification on good standing of privileges at the hospital designated as the primary admitting facility by the physician or good standing at the hospital by another physician with whom the physician has entered into an arrangement for hospital coverage.
6. Attestation on total active patient load is no more than three thousand (3,000) patients per physician.
7. Obtain and maintain a contractual relationship with CAQH (ProView).
8. Participate in workgroups with other Managed Care Plans, the Agency and other stakeholders to focus on reducing redundancies in the provider onboarding process.

⁶ Requirements of the State Medicaid Contract.

⁷ All documents requiring primary source verification and evidence of professional liability insurance (PLI) or acceptable alternative must be available in the credentialing file.

9. All providers to be fully enrolled/onboarded within 60-days. The 60-day metric will be measured by the number of days between the day the Managed Care Plan receives a full and complete provider enrollment application and the day the Agency successfully receives the provider on the Managed Care Plan's Provider Network Verification (PVN) file. The Managed Care Plan agrees to submit the date it receives full and complete provider applications to the Agency on the PNV file when requested.
10. Agree to allow the Agency to procure a provider enrollment and/or credentialing vendor for entire Medicaid program, including Managed Care Plan onboarding and credentialing, as determined by the Agency.

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Georgia

Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs) are required to credential providers according to established standards, but no specific credentialing requirements are identified. (GA Comp. Rules and Regulations sect. 120-2-80-.08(2) (f).

HMOs are required to maintain the current license⁸ or registration number for all licensed independent practitioners (LIPs). (GA Comp. Rules and Regulations sect. 290-5-37-.07(4) (d)).

UnitedHealthcare also accepts the Georgia credentialing forms found at the following link: <http://www.georgiacredentialing.org/applications.html>

⁸ Licenses will be verified at the time of initial credentialing, recredentialing and upon expiration.

Hawaii

No additional credentialing requirements.

Hawaii UnitedHealthcare Community Plan Requirements

Additional query of HI Med-Quest Medicaid Provider Exclusion List is required for Practitioners and Facilities: http://www.med-quest.us/providers/ProviderExclusion_ReinstatementList.html

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Idaho

No additional credentialing requirements.

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Illinois

Laws and regulations apply to health care plans such as Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs), Insurance Companies, etc.

Requirements with respect to health care professionals, such as physicians and chiropractors. Please see the Health Care Professional Credentials Data Collection Act:

1. Health care plans are required to accept, from health care professionals, the Illinois Uniform Health Care Credentials form and may require the health care professional to submit any additional credentials data requested.
2. Each health care plan must complete the process of credentialing or recredentialing of the health care professional within 60 days after submission of all credentials data and completion of verification of the credentials data. 410 ILCS 517/15(f); 77 Ill. Adm. Code 965.140(b).
3. a) All health care plans must obtain recredentialing data on a health care professional according to the single credentialing cycle except when a:
 - health care professional submits initial credentials data to a health care plan;
 - health care professional's credentials data change substantively; or
 - health care plan requires recredentialing as a result of patient or quality assurance issues. (410 ILCS 517/20; 77 Ill. Adm. Code 965.300)
- b) Data collection for health care plans will coincide with a single credentialing cycle that entitles health care plans to collect recredentialing data once, and not more than every three years, except as noted in Section 3(a). (77 Ill. Adm. Code 965.300).
- c) Data collection:
 - will be based on the last digit of each health care professional's Social Security number;
 - will provide for a one-month notification period for each digit during which each health care plan notifies those persons being recredentialed of the time period during which data is expected to be submitted; and
 - will provide for a two-month collection period for each digit during which each health care plan receives data from those persons being recredentialed. (77 Ill. Adm. Code 965.300)
- d) The single credentialing cycle reflects a six month "OPEN" period when health care plans cannot collect data from a health care professional, except as noted in Section 3(a). (77 Ill. Adm. Code 965.300)
- e) Once recredentialing has begun in accordance with the single credentialing cycle, a health care plan may continue to request data from a health care professional outside of the published single credentialing cycle if it is not submitted by the deadline date. (77 Ill. Adm. Code 965.300).
- f) Illinois law does not preclude a health care plan from meeting any quality assurance requirement of an entity related to credentialing for the purpose of accreditation or otherwise. (77 Ill. Adm. Code 965.300).
- g) A health care plan may apply to the Director of Insurance via letter for an exemption from the single credentialing cycle. (77 Ill. Adm. Code 965.310).
4. Health care plans may delegate credentialing and recredentialing activities as long as the delegated entity follows the requirements set forth in the Health Care Professional Credentials Data Collection Act. (410 ILCS 517/15(k); 77 Ill. Adm. Code 965.140(e)).

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Indiana

Insurers, Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs) are required to (pursuant to Indiana (IN) statutes: 27-13-43-2 (HMO), and 27-8-11-7(Insurer/PPO) :

1. Use the Uniform Credentialing Application from the Council for Affordable Quality Healthcare (CAQH), and:
 - Notify a provider of any deficiency within 30 days of receiving the completed application;
 - Notify the provider of the status of the completed credentialing application no later than 60 days after receiving the completed application; and
 - Notify the provider every 30 days until the credentialing determination is final.

Effective July 1, 2018 IN statutes for HMOs (13-43-3) and Insurers/PPOs (27-8-11-7):

Insurer or HMO required to provisionally credential provider if credentialing determination is not issued within 30 days after receiving a complete credentialing application AND the provider meets all of the following criteria:

1. The provider has submitted a completed and signed credentialing application form and any required supporting material; and
2. The provider was previously credentialed in IN by the insurer/HMO in the same scope of practice for which the provider has applied for provisional credentialing (no time frame for previous credentialing is noted); and
3. The provider is a member of a participating provider group; and
4. The provider is [currently] a network provider with the insurer/HMO.

Iowa

A health insurer is responsible to notify a physician of its credentialing determination within 90 days of receiving a completed initial credentialing application from the physician.
(191 Iowa Adm. Code 70.10(514F) (3) (b)).

Iowa UnitedHealthcare Community Plan Requirements⁹

Inclusion of data from quality improvement activities at the time of recredentialing.

Federal database checks on Practitioners and Facilities of the National Plan and Provider Enumeration System (NPPES), the Office of Inspector General List of Excluded Individuals/Entities (OIG/LEIE) and the General Services Administration's System for Awards Management (GSA/SAM) (the successor to the Excluded Parties List System (EPLS)) prior to credentialing/rec credentialing decision.

Additional query of State Medicaid Provider Sanctions List is required for Practitioners and Facilities: <http://dhs.iowa.gov/ime/about/abouttime/program-integrity>

Credentialing of providers applying for network provider status shall be completed as follows: Eighty-five percent (85%) within thirty (30) calendar days; Ninety-eight (98%) percent within forty-five (45) calendar days. The start time begins when all necessary credentialing materials have been received. Credentialing timeliness is measured to include any and all necessary functions performed after complete credentialing packet materials are submitted by the provider, including but not limited to credentialing committee and onsite provider reviews. If the Contractor requests additional materials, not already submitted by the provider, as a result of committee review the time shall not be measured while the Contractor is waiting for the requested materials. Completion time ends when written communication is mailed or faxed to the provider notifying them of the decision.

Standard required to receive incentive payment. Credentialing of providers applying for network provider status shall be completed as follows: Ninety percent (90%) within twenty (20) calendar days; One hundred (100%) percent within thirty (30) calendar days. The start time begins when all necessary credentialing materials have been received. Completion time ends when written communication is mailed or faxed to the provider notifying them of the decision.

The Iowa Medicaid Universal Provider Enrollment Application must be accepted on Practitioner and Facility Providers in lieu of the UnitedHealthcare Credentialing Application. Request for additional information is allowed on elements not contained in the Iowa Medicaid Universal Provider Enrollment Application in order to consider the application complete.

⁹ Requirements of the State Medicaid Contract.

Kansas

No additional credentialing requirements.

Kansas UnitedHealthcare Community Plan Requirements¹⁰

Complete the credentialing process of all service providers applying for participating provider status within sixty (60) calendar days of receipt of complete application. The start time begins when all necessary credentialing materials have been received. Completion time ends when written communication is mailed or faxed to the provider notifying them of the credentialing decision. Credentialed providers must be entered/loaded into the claims payment system within thirty (30) calendar days of credentialing committee approval.

Federal database checks on Practitioners and Facilities of the National Plan and Provider Enumeration System (NPPES), the Office of Inspector General List of Excluded Individuals/Entities (OIG/LEIE) and the General Services Administration's System for Awards Management (GSA/SAM) (the successor to the Excluded Parties List System (EPLS)) prior to credentialing/recredentialing decision.

Additional query of KS Medicaid Terminated Provider List is required for Practitioners and Facilities: http://www.kdheks.gov/hcf/medicaid_program_integrity/index.htm. The Kansas Joint Credentialing Application must be accepted on Facility Providers in lieu of the UnitedHealthcare Credentialing Application.

KMAP ID – UHN network recredentialing provider listings supplied to C&S Operations for validation function.

The State may decide to contract with or require the contractor to contract with a single credentialing verification organization (CVO) to standardize provider credentialing and re-credentialing processes across the KanCare program. The contractor shall work with the State on implementing any new processes related to centralized credentialing.

¹⁰ Requirements of the State Medicaid Contract.

Kentucky

Insurers, Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs) are:

1. Required to accept either the Council for Affordable Quality Healthcare (CAQH) provider application or the Kentucky (KY) Application for Provider Evaluation and Reevaluation Part A (KAPER-1). (KY Administrative Regulations – 806 KAR 17:480.) Insurer/HMO/PPO may accept the CAQH application in lieu of KAPER-1.
2. When KAPER-1 is used, additional information that is not relevant to the scope of practice, health care setting, or service of the health care provider, is not to be requested and may not be recredentialed more frequently than every three years.
 - a) Within 30 days of receipt of a complete KAPER-1 (12/05), Part A, electronically or in writing:
 - i) Notify the health care provider of any omitted and questionable information included on the form; and
 - ii) Offer assistance to the provider.
 - b) Within 60 days of receipt of KAPER-1 (12/05), Part A, provide notification electronically or in writing to the health care provider of the status of credentialing. This time period may be extended if, due to extenuating circumstances:
 - i) Additional time is required by the insurer to consider information submitted on the KAPER-1 (12/05), Part A; and
 - ii) The health care provider is informed of the need for more time, including information relating to the extenuating circumstance which caused the delay. Provide electronic or written notification as established in paragraph C of this sub-section every 30 days after the initial notification until a final determination regarding credentialing has been issued to the health care provider.
 - c) Provide electronic or written notification every 30 days after the initial notification until a final determination regarding credentialing has been issued to the health care provider.
3. When CAQH is used an insurer issuing a managed care plan shall notify an applicant of its determination regarding a properly submitted application for credentialing within 90 (HB 69, Section 8 amends KRS 302.17A-576 Effective 1.1.2019 – 45 days) days of receipt of an application containing all information required by the most recent version of the CAQH credentialing form. Effective July 15, 2008, nothing in this section shall prevent an insurer from requiring information beyond that contained in the credentialing form to make a determination regarding the application. (304.17A-576).
4. Required to appoint a KY-licensed medical director (KY Revised Statutes section 304-17A-545).
5. The recredentialed process is to include an assessment of data collected through quality improvement activities. (KY Revised Statutes section 304.17A-545(4) (d).).

Rev 07/2011, 08/2011, 03/2012, 11/2012, 11/2013, 5/2014, 10/2014, 3/2015, 08/2015, 12/2015, 03/2016, 06/2016, 11/2016, 2/2017, 6/2017, 11/2017, 01/2018, 07/2018, 10/2018, 01/2019

Insurance and/or HMO regulations apply to all Commercial, Medicare and Medicaid products/health plans sold in each applicable state.

Insurance coverage provided by UnitedHealthcare Insurance Company or its affiliates. Health plan coverage provided by UnitedHealthcare of Arizona, Inc.; UnitedHealthcare of California, UnitedHealthcare of Colorado, Inc.; UnitedHealthcare of Oregon, Inc.; UnitedHealthcare of Utah, Inc.; and UnitedHealthcare of Washington, Inc. or other affiliates. Administrative services provided by United HealthCare Services, Inc. or its affiliates.

Louisiana

Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs) are required to:

1. Accept either the Louisiana (LA) Standardized Credentialing Application form, or its successor, or the current form used by the Council for Affordable Quality Healthcare (CAQH). (LA Revised Statutes sect. 22:1009(B) (3)).
2. Notify provider applicants of all defects rendering the application incomplete within 30 days of receipt. (LA Revised Statutes sect. 22:1009(B) (2) (a)).
3. If the information is not received, notify the provider applicant within 60 days of request for additional information. (LA Revised Statutes sect. 22:1009 (B) (2) (b)).
4. Complete credentialing process within 90 days from receipt of all information needed for credentialing. (LA Revised Statutes sect. 22:1009 (B) (1)).

Louisiana UnitedHealthcare Community Plan Requirements¹¹

1. The MCO shall completely process credentialing applications from all types of provider types within sixty (60) calendar days of receipt of a completed credentialing application, including all necessary documentation and attachments, and a signed provider agreement. Completely process shall mean review, approve and load applicants to its provider files in its claims processing system.
2. If the MCO declines request of providers to be included in the network, the MCO must give the requested providers written notice of the reason for its decision within fourteen (14) calendar days of its decision [42 CFR §438.12(a)(1)]
3. In accordance with DHH's credentialing requirements DHH will have final approval of the delegated entity.
4. UnitedHealthcare Community Plan encourages all participating physicians who are not yet board certified to become board certified.
5. Federal database checks on Practitioners and Facilities of the National Plan and Provider Enumeration System (NPPES), the Office of Inspector General List of Excluded Individuals/Entities (OIG/LEIE) and the General Services Administration's System for Awards Management (GSA/SAM) (the successor to the Excluded Parties List System (EPLS)) prior to credentialing/recredentialing decision.
6. Additional requirements for verification of sanctions on Practitioners and Facilities through the Louisiana Exclusion Database. <https://adverseactions.dhh.la.gov/>
7. Recredentialing (L.A.Revised Statutes sect. 46:§ 460.72 – MCO shall comply with the following notice provisions regarding contracted provider re-credentialing:
 - a) MCO shall provide a minimum of three written notices to a contracted provider with information regarding the re-credentialing process, including requirements and deadlines for compliance. The first notice shall be issued by the MCO no later than six months prior to the expiration of the provider's current credentialing. The notice shall include the effective date of termination if the provider fails to meet the requirements and deadlines of the re-credentialing process.
 - b) The MCO shall send the written notice to the last mailing address and last email address submitted by the provider.
 - c) If the provider fails to submit all required documents and meet all re-credentialing requirements, the MCO shall send a termination notice via certified mail to the provider's last mailing address with an effective date of termination to be fifteen days after the date of the notice.

¹¹ Requirements of the State Medicaid Contract.

Maine

Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs) are required to:

1. Obtain primary source verification of hospital privileges on initial credentialing and recredentialing. (Code of Maine (ME) Rules 02-031-850 sections (7) (G) (8) (b) and (7)(G)(10)(b)).
2. Obtain primary source verification, or secondary verification from the National Practitioner Data Bank (NPDB), of the health professional's license history for the preceding 10 years in ME and all other states, including a chronological history of the license, dates, times and places of all applications for license privileges, any action taken on the application, any challenges to licensure or registration, or the voluntary or involuntary relinquishment of a license.
(Code of ME Rules 02-031-850 section (7)(G)(9)(a)).
3. Make credentialing decisions within 60 days of receipt of a completed credentialing application. Time period may be extended upon written notification to provider that the application requires additional time for verification. All credentialing decisions must be made within 180 days of receipt of a completed application. ((Code of ME Rules 02-031-850 section (7)(G)(2)).
4. Offer an appeal procedure, including the right to a hearing, for dealing with provider concerns relating to the denial of credentialing for not meeting the objective credentialing standards of the plan and the contractual relationship between the provider and HMO/PPO. (24 A.M.R.S. § 4303).

Rev 07/2011, 08/2011, 03/2012, 11/2012, 11/2013, 5/2014, 10/2014, 3/2015, 08/2015, 12/2015, 03/2016, 06/2016, 11/2016, 2/2017, 6/2017, 11/2017, 01/2018, 07/2018, 10/2018, 01/2019

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Maryland

Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs) are required to:

1. Accept the uniform credentialing form, and are prohibited from requesting additional information. This also applies to credentialing Delegated Entities that are not hospitals or academic medical centers. (Code of Maryland (MD) Regulations sections 31.10.26.01 et. seq. and MD Ins. Code sect. 15-112.1(c)).
2. Return incomplete applications to applicants within 10 days of receipt, identifying additional information required. (MD Insurance Code section 15-112(d)(4)).
3. Upon receipt of a completed application, notify applicants within 10 days that application is complete. If the application is received via an online credentialing system (e.g. Council for Affordable Quality Healthcare), and the online credentialing system notifies the applicant that the application has been received by the carrier, the HMO/PPO is not required to notify the applicant directly. (MD Insurance Code 15-112 (d)(4)(l)).
4. Notify applicants within 30 days of receipt of completed application of intent either:
 - a) to continue to process the application, or
 - b) to reject application. (MD Insurance Code section 15-112(d)(3)(i)).
5. Process accepted applications within 120 days of notice. Inform providers that the application will be processed, with final determination of whether application accepted or rejected. (MD Insurance Code section 15-112(d)(3)(iii)).
6. Verify whether or not provider is accepting new patients at initial credentialing and recredentialing, and update online directory accordingly. (MD Insurance Code sections 15-112(b)(4) and (j)).¹²
7. Maintain an application log with the following information:
 - Name of provider requesting application
 - Date provider requested application
 - Date application sent or delivered to provider
 - Date application received from provider
 - Date application returned to provider with request for additional information
 - Date received back from provider following request for additional information
 - Date provider notified of rejection or intent to continue credentialing process
 - Date of acceptance or rejection upon completion of credentialing process (Code of MD Regulations sect. 31.10.16.03(D).)

HMOs are also required to assess performance of physicians and nurse practitioners on recredentialing based on an analysis of data obtained through quality improvement activities.

Maryland UnitedHealthcare Community Plan Requirements¹³

1. Site visits at the time of initial credentialing for primary care physicians (PCP), to include assessment of Americans with Disabilities Act (ADA) compliance.
2. Assessment of ADA compliance for any new office site for primary care physicians.
3. Practitioners and Facilities to be screened for Medicare/Medicaid exclusions from additional sources including National Practitioner Data Bank (NPDB), Office of the Inspector General List of Excluded Individuals and Entities (OIG-LEIE) and General Services Administration System for Awards Management (GSA-SAM) (the successor to the Excluded Parties List System (GSA-EPLS)).

¹² Open panel status is not a criterion for participation

¹³ Requirements of the State Medicaid Contract.

4. Additional query of MD Medicaid Providers Sanctioned List is required for Practitioners and Facilities: <https://mmcp.dhmh.maryland.gov/pages/Provider-Information.aspx>
5. Review of Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Certification as applicable. EPSDT Applies to PCP only. (General Practitioner, Family Practitioner, Pediatrics, and Nurse Practitioners).

Rev 07/2011, 08/2011, 03/2012, 11/2012, 11/2013, 5/2014, 10/2014, 3/2015, 08/2015, 12/2015, 03/2016, 06/2016, 11/2016, 2/2017, 6/2017, 11/2017, 01/2018, 07/2018, 10/2018, 01/2019

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Massachusetts

Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs) are required to (211 Code of Massachusetts. Regulations. 52.09):

1. Comply with National Committee for Quality Assurance Managed Care Organization accreditation standards for credentialing and recredentialing, and are permitted to adopt additional credentialing criteria.
2. Accept credentialing/recredentialing applications in a format specified by the Commissioner, and submitted in paper or electronic format, including facsimile and electronic mail. An online process for the purpose of processing credentialing applications may be implemented. A credentialing application which is appropriately signed and dated by the Provider, and which includes all of the applicable information requested from the Provider by the Carrier. The Massachusetts credentialing forms can be found at the Massachusetts Medical Society website: <http://www.massmed.org/Physicians/Practice-Management/Practice-Ownership-and-Operations/Massachusetts-Uniform-Credential-Applications/#.WfzCldLfPcs>
3. Notify the applicant if application is incomplete no later than 20 business days after receipt.
4. Notify initial credentialing applicant within 75 days of receipt of the status of the application, including reasons for any delay in completion and a timeline of the expected resolution of the application.
5. Complete 95% of clean and complete initial credentialing applications within 60 days of receipt.
6. Complete 95% of clean and complete recredentialing applications within 120 days of receipt.
7. A Carrier that delegates to or contracts with another entity for the performance of some or all of the functions governed by 211 CMR 52.00 shall be responsible for ensuring compliance by said entity with the provisions of 211 CMR 52.00. (211 CMR 52.01.)

Massachusetts UnitedHealthcare Community Plan Requirements¹⁴

Inclusion of data from quality improvement activities at the time of recredentialing.

Practitioners and Facilities to be screened for Medicare/Medicaid exclusions from additional sources including the Office of the Inspector General List of Excluded Individuals and Entities (OIG-LEIE) and General Services Administration System for Awards Management (GSA-SAM) (the successor to the Excluded Parties List System (EPLS)).

Additional query on List of Suspended or Excluded MassHealth Providers is required for Practitioners and Facilities:
<http://www.mass.gov/eohhs/gov/newsroom/masshealth/providers/list-of-suspended-or-excluded-masshealth-providers.html>

Primary Care Physicians in the Senior Care Options Product, (MDs/DOs, NPs and PAs practicing as Internal Medicine, Family Practice, Geriatric Medicine, and/or OB/GYN) are required to complete annual continuing medical education (CME) units in geriatric practice and at least two years of experience in the care of people over the age of 65.

¹⁴ Requirements of the State Medicaid Contract.

Michigan

Health Maintenance Organizations (HMOs) are required per (Michigan Compiled Laws Service sections 500.3528 and 500.3531 to:

1. Obtain primary verification of health professional's current professional liability coverage¹⁵, and status of hospital privileges, if applicable.
2. Obtain primary verification of: current professional liability coverage and status of hospital privileges, if applicable, every three years.
3. Monitor delegated entities for compliance with these requirements.

Michigan UnitedHealthcare Community Plan Requirements^{16,17}

Federal database checks on Practitioners and Facilities of the National Plan and Provider Enumeration System (NPPES), the Office of Inspector General List of Excluded Individuals/Entities (OIG/LEIE) and the General Services Administration's System for Awards Management (GSA/SAM) (the successor to the Excluded Parties List System (EPLS)) prior to credentialing/recredentialing decision.

Additional requirements for Practitioner and Facility verification of sanctions including but not limited to the Michigan Department of Community Health (MDCH)/Medical Services Administration (MSA) Sanctioned Provider List.

¹⁵ A copy of professional liability declaration sheet will serve as evidence of primary source verification.

¹⁶ If the provider is enrolled directly with the MI Medicaid program (proof of which is verified and contained in the credentialing file) there is no further requirement that the health plan query certain databases such as the NPPES, Death Master File or the MDCH.

¹⁷ Requirements of the State Medicaid Contract.

Minnesota

No additional credentialing requirements.

Rev 07/2011, 08/2011, 03/2012, 11/2012, 11/2013, 5/2014, 10/2014, 3/2015, 08/2015, 12/2015, 03/2016, 06/2016, 11/2016, 2/2017, 6/2017, 11/2017, 01/2018, 07/2018, 10/2018, 01/2019

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Mississippi

Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs) are required to follow Weil's Code of Mississippi Rules 28 000 072. reg. 98.1 to:

1. Accept the state uniform credentialing application from physicians for initial credentialing and recredentialing.
2. Augment the uniform credentialing application with additional information on supplemental form.
3. Obtain prior approval from the Commissioner of Insurance for supplemental form to the uniform credentialing application.
4. Obtain primary verification of hospital privileges to practitioner's primary admitting hospital at initial credentialing and subsequent recredentialing.
5. Obtain primary or secondary verification of hospital privileges to hospitals other than practitioner's primary admitting hospital at initial credentialing and recredentialing.
(MS Code Ann. Section 83-41-409).

Mississippi UnitedHealthcare Community Plan Requirements¹⁸

1. Initial site visit to be conducted during credentialing on PCP's & OB/GYN's.
2. CLIA certificate/waiver to be collected on practitioners providing laboratory services at time of credentialing and recredentialing. CLIA number must correspond with the CLIA number on the CAQH application.
3. CLIA certificate/waiver to be collected on facility providers that bills for laboratory services.
4. Federal database checks on Practitioners and Facilities of the National Plan and Provider Enumeration System (NPPES), the Office of Inspector General List of Excluded Individuals/Entities (OIG/LEIE) and the General Services Administration's System for Awards Management (GSA/SAM) (the successor to the Excluded Parties List System (EPLS)) prior to credentialing/rec credentialing decision.
5. All documents requiring primary source verification and evidence of professional liability insurance/ malpractice insurance must be available in credentialing file of practitioner and facility providers.
6. Nurse practitioners acting as PCPs have a formal, written collaborative/consultative relationship with a licensed physician with admitting privileges at a contracted inpatient hospital facility
7. Contractor shall credential all completed application packets within ninety (90) calendar days of receipt. In cases of network inadequacy, the Contractor shall credential all completed application packets within forty-five (45) calendar days of receipt. The Contractor shall notify the Division of any Provider applications requiring longer than ninety (90) calendar days via monthly report.
8. The Health Plan shall notify the Division within ten (10) calendar days of the denial of a Provider credentialing application either for program integrity-related reasons or due to limitations placed on the Provider's ability to participate for program integrity-related reasons. Contractor will load Provider information into its claims processing system within thirty (30) calendar days of credentialing approval.
9. Database query of the National Practitioner Data Bank (NPDB) during credentialing and recredentialing
10. Additional query of State Medicaid Provider Sanctioned List is required for Practitioners and Facilities:
<http://www.medicaid.ms.gov/wp-content/uploads/2014/03/SanctionedProvidersList.pdf>

¹⁸ Requirements of the State Medicaid Contract.

11. Credentialing and recredentialing files should contain a copy of the original attestation with signature for regulatory audits. Electronic re-attestments from CAQH are acceptable as long as a copy of original signature is in the file.
12. All credentialing decisions are reviewed and approved by the Provider Advisory Committee (PAC) which is the local credentialing committee. Committee members consist of participating Mississippi Medicaid Providers and the Committee is chaired by the Local Chief Medical Officer.
13. Disclosure of Ownership Form needs to be collected on practitioner and facility providers. This information needs to be reflected in the credentialing/recredentialing files.

Rev 07/2011, 08/2011, 03/2012, 11/2012, 11/2013, 5/2014, 10/2014, 3/2015, 08/2015, 12/2015, 03/2016, 06/2016, 11/2016, 2/2017, 6/2017, 11/2017, 01/2018, 07/2018, 10/2018, 01/2019

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Missouri

Laws and regulations apply to health carriers, meaning, Health Maintenance Organizations (HMOs).

Requirements with respect to health care professionals, such as physicians, chiropractors, dentists and any other health care practitioners who are licensed, accredited or certified by the state of Missouri to perform specified health services consistent with state law:

1. The Universal Credentialing Datasource form (Form UCDS), incorporated by reference and published on October 31, 2006, by the Council for Affordable Quality Healthcare (CAQH), has been adopted and shall be used by all health carriers and their agents when credentialing or recredentialing health care professionals in a managed care plan. (20 CSR 400-7.180 (2011))
 - a) If the health carrier receives the CAQH credentialing form via fax or mail, the health carrier is required to send notice of receipt to the practitioner. (376.1578(1) R.S. Mo.)
 - b) If the CAQH credentialing form is submitted electronically, the health carrier is required to provide notice of the status via provider web portal. . (376.1578(1) R.S. Mo.)
2. Health carriers may request additional information to explain or provide details regarding responses obtained on the standard form. Health carriers are prohibited from routinely requiring additional information from health care professionals. (20 CSR 400-7.180(3)).
3. If the health carrier demonstrates a need for additional information, the director of the Department of Insurance may approve a supplement to the standard credentialing form. All forms and supplements must meet all requirements as defined by National Committee for Quality Assurance (NCQA).
§ 354.442 R.S.Mo.
4. An onsite examination by the health carrier or their agent of the health care professional's place of business must not, in itself, be considered a routine request for additional information.
(20 CSR 400-7.180(4)).
5. A health carrier may require a health care professional to sign an affirmation and release of the health carrier's own design. (20 CSR 400-7.180(5)).
6. Health carrier required to disclose to enrollees a listing by specialty of all participating providers, including facilities. (Sect. 354.442 (14) R.S.Mo.) Per NCQA, the organization would not need to credential facility based practitioners since members are being directed to the facility even though the practitioners are required to be in the directory per the state law referenced above. The organization should provide the regulatory requirement when it submits its survey documentation.¹⁹
7. Health carrier required to make a decision whether to approve or deny a practitioner's credentialing application within 60 business days of receipt of completed credentialing application. (Rev. Stat. MO sect. 376.1578(2)).
 - a) The 60 business day deadline shall not apply if the credentialing application or subsequent verification indicates that the practitioner has:
 - i) a history of behavioral disorders or other impairments affecting the practitioner's ability to practice, including but not limited to substance abuse;
 - ii) Licensure disciplinary actions against the practitioner's license to practice imposed by any state or territory or foreign jurisdiction;

¹⁹ Per NCQA email 6/28/18

²⁰ Credentialing turn-around time is not applicable to the delegated entities.

²¹ Advanced directive policy determined by the Health Plan.

- iii) Had the practitioner's hospital admitting or surgical privileges or other organizational credentials or authority to practice revoked, restricted, or suspended based on the practitioner's clinical performance; or
- iv) A judgment or judicial award [but not a settlement] against the practitioner arising from a medical malpractice liability lawsuit. (376.1578(2)(1-4) R.S. Mo.)

Missouri UnitedHealthcare Community Plan Requirements

Federal database checks on Practitioners and Facilities of the National Plan and Provider Enumeration System (NPPES), the Office of Inspector General List of Excluded Individuals/Entities (OIG/LEIE) and the General Services Administration's System for Awards Management (GSA/SAM) (the successor to the Excluded Parties List System (EPLS)) prior to credentialing/recredentialing decision.

Additional query of MO Medicaid Terminations List is required for Practitioners and Facilities: <http://mmac.mo.gov/providers/provider-sanctions/>

Credentialing process shall not take longer than sixty (60) business days pursuant to RSMo 376.1578¹⁹

The Health Plan shall load credentialed providers into the claim adjudication and payment system within the following time frames in order to ensure timely denial or payment for a health care service or item already provided to a participant and billed to the health plan by the provider:

- Newly credentialed provider attached to a new contract within ten (10) business days after completing credentialing;
- Newly credentialed hospital or facility attached to a new contract within fifteen (15) business days after completing credentialing;
- Newly credentialed provider attached to an existing contract within five (5) business days after completing credentialing;
- Changes for a re-credentialed provider, hospital, or facility attached to an existing contract within five (5) business days after completing re-credentialing;
- Change in existing contract terms within ten (10) business days of the effective date after the change.

Inclusion of performance monitoring information on records related to advance directives on Primary Care Providers during the time of recredentialing.²⁰

¹⁹ Credentialing turn-around time is not applicable to the delegated entities.

²⁰ Advanced directive policy determined by the Health Plan.

Montana

No additional credentialing requirements.

Rev 07/2011, 08/2011, 03/2012, 11/2012, 11/2013, 5/2014, 10/2014, 3/2015, 08/2015, 12/2015, 03/2016, 06/2016, 11/2016, 2/2017, 6/2017, 11/2017, 01/2018, 07/2018, 10/2018, 01/2019

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Nebraska

The Health Care Credentialing Verification Act applies to health carriers such as Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs), and Insurance Companies, that offer closed plans, meaning plans that require covered persons to use participating providers under the terms of the managed care plan, or combination plans having a closed component.

Requirements with respect to health care professionals such as physicians or any other health care practitioners who are licensed, certified, or registered to perform specified health services consistent with state law:

1. A health carrier must obtain primary verification of:
 - a) Current level of professional liability coverage, if applicable.
 - b) Status of hospital privileges, if applicable.
 - c) Current federal Drug Enforcement Agency registration certificate, if applicable;
 - d) Graduation from a health care professional school; and completion of postgraduate training, if applicable. (R.R.S. Neb. § 44-7007(1)).
2. At least every three years, the health carrier must obtain primary verification of participating health care professionals:
 - a) Current level of professional liability coverage, if applicable.
 - b) Status of hospital privileges, if applicable.
 - c) Current federal Drug Enforcement Agency registration certification, if applicable.
3. Whenever a health carrier contracts to have another entity perform the credentialing functions required by the Health Care Professional Credentialing Verification Act or applicable rules and regulations, the Director of Insurance must hold the health carrier responsible for monitoring the activities of the entity with which it contracts and for ensuring that the requirements of the act and applicable rules and regulations are met. (R.R.S. Neb. § 44-7009).

Nebraska UnitedHealthcare Community Plan Requirements²²

1. Practitioners and Facilities to be screened for Medicare/Medicaid exclusions from additional sources including the Office of the Inspector General List of Excluded Individuals and Entities (OIG-LEIE) and General Services Administration System for Awards Management (GSA-SAM) (the successor to the Excluded Parties List System (EPLS)).
2. The health plan will notify the Medicaid Agency of any disclosures made by providers related to persons convicted of crimes within 10 working days from the date of the MCO receives the information²³
3. Completely process credentialing applications within 30 calendar days of receipt of a completed credentialing application. A completed application includes all necessary documentation and attachments. Completely process means: review, approved, and load approved providers to its provider files in its system or deny, notify provider, and ensure provider is not used for services.
4. MCO must accept any standardized provider credentialing form and/or process for applicable providers within 60 calendar days of its development and/or approval by the administrative simplification committee and MLTC.
5. Inclusion of data from quality improvement activities at time of recredentialing.
6. Additional query of Nebraska Medicaid Excluded Providers List is required for Practitioners and Facilities: http://dhhs.ne.gov/medicaid/Pages/med_pi_sanc.aspx

²² Requirements of the State Medicaid Contract.

²³ Provider Disclosures including disclosure of ownership form and criminal history are collected prior to contract execution following standard health plan procedures

Nevada

Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs) are required to accept the Nevada (NV) Division of Insurance provider application, and may only use a supplemental form to collect additional information required by the state or federal government or an accrediting body.

(NV Adm. Code 679B.0405).

Nevada UnitedHealthcare Community Plan Requirements

Additional query of NV Exclusions/Sanctions is required for Practitioners and Facilities: <http://dhcftp.nv.gov/Providers/PI/PSExclusions/>

Rev 07/2011, 08/2011, 03/2012, 11/2012, 11/2013, 5/2014, 10/2014, 3/2015, 08/2015, 12/2015, 03/2016, 06/2016, 11/2016, 2/2017, 6/2017, 11/2017, 01/2018, 07/2018, 10/2018, 01/2019

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New Hampshire

Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs) per Revised Statutes of New Hampshire (NH) Annotated 420-J:4 – effective Aug. 10, 2007) are:

1. Required to notify a health care provider within 15 business days if a credentialing application is incomplete.
2. Upon receipt of a clean and complete credentialing application, required to finalize the credentialing process within 30 calendar days for primary care physicians (PCP) and 45 days for specialists. “Clean and complete” means that the application is signed and appropriately dated by the health care provider and includes all applicable information required, as well as affirmative responses on questions related to quality and clinical competence.
3. Required to allow on-call coverage for a participating provider by health care providers who have submitted clean and complete applications, and have a valid license from the respective state licensing board and have been credentialed by the hospital.²⁴
4. Required to allow a health care provider to deliver services to covered persons when the health care provider has a valid license from the respective state licensing board, and has been credentialed by the hospital, and the health care provider has been credentialed by the health carrier in another state or in the health carrier’s NH network based on employment with a particular health care entity.
5. When credentialing verification functions are delegated, the carrier is responsible for monitoring the delegated entity and ensuring that the requirements of this section are met.

²⁴ Network requirement not related to the credentialing process.

New Jersey

Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs) (“Carriers”) are required to:

1. Accept the New Jersey (NJ) Universal Physician Application. (NJ Adm. Code 11:24C-1.3).
 - a) May accept other applications, but required to notify physicians of the NJ Application available on the Department of Insurance website.
 - b) May access physician credentialing information from a recognized, national credentialing database, but prohibited from requiring physicians to use a national database.
2. Required to comply with the following response times:
 - a) For physicians who apply by submitting the NJ Universal Physician Application, notify the applicant within 60 days, following the receipt of the application, that the application is incomplete, specifying in writing the information that is missing, otherwise the application shall be deemed complete. (NJ Adm. Code 11:24-3.9)
 - b) For practitioners who apply via the Council for Affordable Quality Healthcare (CAQH) Universal Provider Datasource, notify the applicant within 45 days whether the application is complete or incomplete. Notice may be provided electronically if application contains an e-mail address. In the absence of an e-mail address, notice shall be in writing. If application is incomplete, the notice shall:
 - i) Specify the additional information required and the due date; and
 - ii) Include the phone number and e-mail address of Carrier’s department responsible for accepting information required to complete the application and for providing assistance regarding the credentialing process and the status of the credentialing application. Carriers shall respond to credentialing inquiries within five (5) business days. (NJ Adm. Code 11.24C-1.3(a) (1) and (2).)
3. Complete the initial credentialing process within no more than 90 days of receipt of the complete application. (NJ Adm. Code 11:24-3.9) and NJ Adm. Code 11:24C-1.3)

New Jersey UnitedHealthcare Community Plan Requirements²⁵

1. Database query of the National Practitioner Data Bank (NPDB) during credentialing and recredentialing.
2. Inclusion of performance data, including but not limited to quality indicators and utilization management at the time of recredentialing.
3. Site visits at the time of credentialing for primary care physicians, obstetricians and gynecologists, and dentists (to include American’s with Disabilities Act (ADA) assessment).²⁶
4. Verification of admitting privileges in good standing at a participating hospital
5. Federal database checks on Practitioners and Facilities of the National Plan and Provider Enumeration System (NPPES), the Office of Inspector General List of Excluded Individuals/Entities (OIG/LEIE) and the General Services Administration’s System for Awards Management (GSA/SAM) (the successor to the Excluded Parties List System (EPLS)) prior to credentialing/recredentialing decision.
6. Additional query of NJ Medicaid Debarment List is required for Practitioners and Facilities: <http://nj.gov/comptroller/divisions/medicaid/disqualified/>

²⁵ Requirements of state Medicaid contract.

²⁶ Attestation to ADA compliance and compliance with medical record keeping practices is required. Additional mechanisms other than site visits may be considered as meeting this requirement.

7. Credentialing process shall include notification to practitioners of errors in the credentialing application within three (3) business days of receipt or identification of an error. The credentialing committee shall meet to review credentialing applications monthly and notify each applicant of the status of their application within five (5) business days of the meeting.
8. A dentist with certification in the following specialties: Endodontics, Oral and Oral Maxillofacial Surgery, Periodontics and Prosthodontics must have or have confirmations of application submission, of valid DEA and CDS certificates. As required by the State of New Jersey, any provider that holds a valid DEA or CDS certificate must submit it.

Rev 07/2011, 08/2011, 03/2012, 11/2012, 11/2013, 5/2014, 10/2014, 3/2015, 08/2015, 12/2015, 03/2016, 06/2016, 11/2016, 2/2017, 6/2017, 11/2017, 01/2018, 07/2018, 10/2018, 01/2019

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New Mexico

Requirements for Health Maintenance Organizations (HMOs) and Group Health Insurance. (NM Statutes Annotated section 59A-23-14 and 59A-46-54, and NM Administrative Code sections:13.10.21.9, 13.10.28.10, 13.10.28.11 and 13.10.28.13)

1. When credentialing functions are performed by another entity, the Managed Health Care Plan is required to monitor the delegated entity for compliance with state credentialing/recredentialing regulations.
2. Shall not use any health professional credentialing application form other than the uniform Hospitals Service Corporation or Council for Affordable Quality Healthcare credentialing/recredentialing forms, in electronic or paper format, as determined by the health carrier. Exception to use of these credentialing applications is made for health professionals who practice outside of NM and who prefer to use the credentialing form required by their respective states.
3. Shall notify applicants of its decision to approve or deny the credentialing application within 45 days of receipt of a completed application and all supporting documentation:
 - a) in writing via US mail at the physical address listed in the application; and
 - b) by e-mail if an email address has been provided.
4. Each carrier shall establish an internal process for resolving disputes regarding credentialing between the health carrier and providers. When a provider has not received a decision regarding a credentialing application within 45 days of submitting the completed uniform credentialing application, the provider may request a review of the credentialing application according to the health carrier's internal dispute process.
5. Notify the applicant in writing via U.S. certified mail within 10 working days:
 - a) That the credentialing application has been received; and after receipt of an incomplete application requesting any information or supporting documentation that is required in order to approve or deny the credentialing application. The notice will contain a name, address and telephone for credentialing staff who serve as applicant's point of contact.
6. If additional information or documentation is required from the provider and is requested via certified mail, health carrier shall inform the applicant:
 - a) that the 45-day time period shall be tolled pending receipt of the requested information or documentation.
 - b) In the event that any needed verification or a verification supporting statement has not been received within 60 days of the health carrier's request; and
 - c) If at the end of 90 days an application remains incomplete and the provider has been unresponsive, the health carrier shall return the application and attached materials with a statement of rejection.
7. Health carrier shall not require applicant to submit information not required by the uniform credentialing form, other than information or documentation that is reasonably related to information on the application.
8. Health carriers required to establish program that verifies provider credentialing before accepting the provider into the network and listing the provider in the directory.
9. Health carrier not obligated to approve all credentialing applications and may deny any application based on existing network adequacy, issues with application, failure by provider to complete credentialing application, or another reason.
10. Each carrier shall develop and adopt a written credentialing plan to support the credentialing verification program, and which shall be provided to the superintendent of insurance upon request.

Rev 07/2011, 08/2011, 03/2012, 11/2012, 11/2013, 5/2014, 10/2014, 3/2015, 08/2015,12/2015, 03/2016, 06/2016,11/2016, 2/2017, 6/2017, 11/2017, 01/2018, 07/2018, 10/2018, 01/2019

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11. Each carrier shall submit a report to the superintendent of insurance regarding its credentialing process every two years. The report shall include the following: the amount of time taken to review and reach a determination on an application and the number of: applications made to the plan, applications approved by the plan, applications rejected by the plan, and providers terminated for reasons of quality.
12. Recredentialing may not be required more frequently than every three years. Health carrier will notify applicant at least 120 days in advance of all items necessary to complete recredentialing. The recredentialing process must be completed within 45 days of receipt of the applicant's complete recredentialing application and all supporting documents. If application is approved provisionally, then recredentialing shall be required annually. Nothing in this section shall be construed to require a health carrier to credential or provisionally recredential any provider. A health carrier may not require a participating provider to be recredentialled based on a change in provider's TIN or TIN of provider's employer, a change in provider's employer if the new employer is a participating provider or also employs other participating providers.

Rev 07/2011, 08/2011, 03/2012, 11/2012, 11/2013, 5/2014, 10/2014, 3/2015, 08/2015, 12/2015, 03/2016, 06/2016, 11/2016, 2/2017, 6/2017, 11/2017, 01/2018, 07/2018, 10/2018, 01/2019

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New York

In New York (NY), Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs) are required to notify health care professionals within 60 days of receipt of a completed application as to: (i) whether the provider is credentialed; or (ii) whether additional time is necessary to make a determination because of a failure of a third party to provide necessary documentation. In such instances where additional time is necessary because of a lack of necessary documentation, a health plan shall make every effort to obtain such information as soon as possible and shall make a final determination within 21 days of receiving the necessary documentation.

(NY Con. Law Svc. Ins. 4803)(a) and NY Public Health Law section 4406-d (1)(a)).

Additionally, NY HMO and PPOs are required to provisionally credential health care professionals under the following conditions:

1. If the insurer, within 60 days of submission of the completed application, has neither approved nor declined the application of a newly-licensed health care professional who joins a participating group practice; or
2. If the insurer, within 60 days of submission of the completed application, has neither approved nor declined the application of a health care professional who has not previously practiced in NY and has recently relocated to NY from another state, to join a participating group practice; and
3. The group practice notifies the insurer in writing that, should the health care professional's application ultimately be denied, the health care professional or the group practice:
 - a) Refund any payments made by the insurer for in-network services provided by the provisionally credentialed health care professional that exceed any out-of-network benefits payable under the member's coverage plan with the insurer; and
 - b) Not pursue reimbursement from the member, except to collect the copayment or coinsurance that otherwise would have been payable had the enrollee received services from a health care professional participating in the insurer's network.
4. However, a provisionally credentialed physician may not be designated as a member's primary care physician until such time as the physician has been fully credentialed.

(NY Con. Law Svc. Ins. 4803(b), and NY Public Health Law section 4406-d (1)(b)).

New York UnitedHealthcare Community Plan Requirements²⁷

Additional query of state Medicaid Sanctioned Provider List is required on Practitioners and Facilities in addition to state licensing boards query.(<http://omig.state.ny.us/data/content/view/72/52/>; (10NYCRR 98.12(1)).

Federal database checks on Practitioners and Facilities of the National Plan and Provider Enumeration System (NPPES), the Office of Inspector General List of Excluded Individuals/Entities (OIG/LEIE) and the General Services Administration's System for Awards Management (GSA/SAM) (the successor to the Excluded Parties List System (EPLS)) prior to credentialing/recredentialing decision.

²⁷ Requirements of state Medicaid contract

North Carolina

Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs) are required to:

1. Accept the state uniform provider credentialing application for licensed health care practitioners. (North Carolina (NC) Gen. Stat. 58-3-230)
2. Notify the practitioner within 30 days if the application is not accepted for reasons not related to credentialing.
3. Make a credentialing determination within 60 days of receipt of completed application. (NC Gen. Stat. sect. 58-3-230(a); 11 NC Adm. Code 20.0405).
 - a) If the application is incomplete, it is required to notify the provider within 15 days of all missing or incomplete information or supporting documents.
 - b) If the missing information is not received within 60 days, it is acceptable to close the application or delay the final review pending receipt of the necessary information.
 - c) If insurer has not approved or denied the application within 60 days of receipt of the completed application, within five business days of receipt of a written request from the applicant, the insurer is required to issue a temporary credential to the applicant if the applicant has a valid NC professional or occupational license.
 - i) The insurer shall not issue a temporary credential if the applicant has reported a history of: malpractice claims, substance abuse, mental health issues, or licensing board disciplinary actions.
 - ii) The temporary credential is effective upon issuance and will remain in effect until the credentialing application is approved or denied.
4. Whenever credential verification activities are delegated to a contracting entity, require the contracting entity to comply with all applicable requirements in the NC Adm. Code related to credentialing. (NC Adm. Code 20.0410)

North Carolina UnitedHealthcare Community Plan Requirements

Federal database checks on Practitioners and Facilities of the National Plan and Provider Enumeration System (NPPES), the Office of Inspector General List of Excluded Individuals/Entities (OIG/LEIE) and the General Services Administration's System for Awards Management (GSA/SAM) (the successor to the Excluded Parties List System (EPLS)) prior to credentialing/recredentialing decision.

Additional query of the North Carolina Medicaid Provider Termination and Exclusion list is required for Practitioners and Facilities: <https://medicaid.ncdhhs.gov/providers/excluded-providers>

Credentialing to be completed ninety percent (90%) of providers within thirty (30) calendar days of the Committee's receipt of complete credentialing and verified information for consideration; and one hundred percent (100%) of providers within forty-five (45) calendar days of the Committee's receipt of complete credentialing and verified information for consideration of the Provider Network Participation Committee's determination.

The Health Plan shall provide written notice of credentialing Quality Determinations to providers within five (5) business days of the Provider Network Participation Committee's determination.

The NC Department of Health and Human Services (the Department) will establish a centralized credentialing process including a standardized provider enrollment application and qualification verification process.

The Department will engage a Provider Data Management/Credential Verification Organization (PDM/CVO), where the CVO is certified by the National Committee on Quality Assurance (NCQA), to facilitate the enrollment process including the collection and verification of provider education, training, experience and competency.

The information gathered by the Department will be shared with the Health Plans to use the information to make Credentialing Quality Determinations for network contracting purposes.

The Health Plan shall accept provider credentialing and verified information from the Department, or designated Department vendor, and shall not request any additional credentialing information from a provider without the Department's written prior approval.

The Health Plan shall make a Quality Determination based solely upon the credentialing information provided by the Department and shall not require a provider to submit any additional information to be used in the Quality Determination. Health Plan shall meet with the Department, or designated Department vendor, quarterly and as requested regarding the credentialing and network contracting process.

Health Plan shall establish and maintain a Provider Network Participation Committee to make Quality Determinations. Chief Medical Officer (CMO) or CMO designee shall serve as the chair of the Provider Network Participation Committee. The chair must be a North Carolina licensed physician.

Health Plan may establish criteria to define a provider's file as a clean file and a review process for clean files. The review process must include that a clean file is reviewed by the Chief Medical Officer, but review by the Provider Network Participation Committee is not required.

Prohibit contracting with providers who are not enrolled with the Department as NC Medicaid providers consistent with screening and enrollment requirements of 42 C.F.R. Part 455 Subparts B and E.

The Health Plan shall load credentialed providers into the claim adjudication and payment system within the following time frames in order to ensure timely denial or payment for a health care service or item already provided to a Member and billed to the health plan by the provider:

- Newly credentialed provider attached to a new contract within ten (10) business days after completing credentialing;
- Newly credentialed hospital or facility attached to a new contract within fifteen (15) business days after completing credentialing;
- Newly credentialed provider attached to an existing contract within five (5) business days after completing credentialing;
- Changes for a re-credentialed provider, hospital, or facility attached to an existing contract within five (5) business days after completing re-credentialing;
- Change in existing contract terms within ten (10) business days of the effective date after the change; and
- Changes in provider service location or demographic data or other information related to Member's access to services must be updated no later than thirty (30) calendar days after the PHP receives updated provider information. (End bullets here)

The Health Plan shall submit any significant policy changes to Objective Quality Standards to the Department for review and approval at least sixty (60) calendar days prior to implementing such changes.

The Health Plan shall suspend claims payment to any provider for Dates of Services after the effective date provided by the Department in its network within one (1) business day of receipt of a notice from the Department that Provider payment has been suspended for failing to submit re-credentialing documentation to the Department or otherwise fail to meet Department requirements.

- The Health Plan shall reinstate payment to the provider upon notice that the Department has received the requested information from the provider. If the provider does not provide the information with fifty (50) days of suspension, the Department will terminate the provider from Medicaid.

North Dakota

No additional credentialing requirements.

Rev 07/2011, 08/2011, 03/2012, 11/2012, 11/2013, 5/2014, 10/2014, 3/2015, 08/2015, 12/2015, 03/2016, 06/2016, 11/2016, 2/2017, 6/2017, 11/2017, 01/2018, 07/2018, 10/2018, 01/2019

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Ohio

Laws and regulations apply to a health insuring corporation such as Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs) and Insurance Companies.

The following laws (ORC Ann. 3963.01, 3963.05 and 3963.06) apply to a “contracting entity,” meaning, any person that has a primary business purpose of contracting with participating providers for the delivery of health care services (e.g. HMOs, PPOs, Insurance Companies).

Requirements with respect to what constitutes a “Provider”. A “Provider” can be a physician, podiatrist, dentist, chiropractor, optometrist, psychologist, physician assistant, advanced practice nurse, occupational therapist, massage therapist, physical therapist, professional counselor, professional clinical counselor, hearing aid dealer, orthotist, prosthetist, home health agency, hospice care program, or hospital, or a provider organization or physician-hospital organization that is acting exclusively as an administrator on behalf of a provider to facilitate the provider’s participation in health care contracts. A “Provider” is not a pharmacist, pharmacy, nursing home, or a provider organization or physician-hospital organization that leases the provider organization’s or physician-hospital organization’s network to a third party or contracts directly with employers or health and welfare funds. (ORC Ann. 3963.01(P)).

1. The Department of Insurance must prescribe the credentialing application form used by the Council for Affordable Quality Healthcare (CAQH) in electronic or paper format for physicians. Also, the Department of Insurance must prepare the standard credentialing form for all other providers, except hospitals. (ORC Ann. 3963.05(A) and (E)).

The Ohio Department of Insurance (OH DOI) has adopted the CAQH credentialing form, in electronic or paper format, for credentialing of physicians and non-physician individual providers. (Referred to as “Department of Insurance Part A credentialing form.”) (OH Adm. Code 3901-1-58(C).)

OH DOI has designated the DOI Part B credentialing form to be used to credential hearing aid dealers, home health agencies, hospice care providers and all other providers that are not individuals, with the exception of hospitals. Copies of this form may be obtained from the OH DOI. (OH Adm. Code 3901-1-58(C).)

2. A contracting entity must use the applicable standard credentialing form described in the preceding paragraph when initially credentialing or recredentialing providers in connection with policies, health care contracts, and agreements providing basic health care services, specialty health care services, or supplemental health care services. (ORC Ann. 3963.05.)
3. A contracting entity cannot require a provider to supply additional information other than what is required by the applicable standard credentialing form described in paragraph 1 above in connection with policies, health care contracts, and agreements providing basic health care services, specialty health care services, or supplemental health care services. (ORC Ann. 3963.05.)
4. The credentialing process outlined in Ohio (OH) law does not prohibit a contracting entity from limiting the scope of any participating provider’s basic health care services, specialty health care services, or supplemental health care services. (ORC Ann. 3963.05).
5. If a provider, upon the oral or written request of a contracting entity to submit a credentialing form, submits a credentialing form that is not complete, the contracting entity that receives the form must notify the provider of the deficiency electronically, by facsimile, or by certified mail, return receipt requested, no later than 21 days after the contracting entity receives the form. (ORC Ann. 3963.06).
6. If a contracting entity receives any information that is inconsistent with the information given by the provider in the credentialing form, the contracting entity may request the provider to submit a written clarification of the inconsistency. The contracting entity must send the request described in this section electronically, by facsimile, or by certified mail, with return receipt requested. (ORC Ann. 3963.06).

7. a) Except as otherwise provided in section 7B below, the credentialing process starts when a provider initially submits a credentialing form upon the oral or written request of a contracting entity, and the provider must submit the credentialing form to the contracting entity electronically, by facsimile, or by certified mail, with return receipt requested. Subject to section 7C, a contracting entity must complete the credentialing process not later than 90 days after the contracting entity receives the credentialing form from the provider. The contracting entity must allow the provider to submit a credentialing application prior to the provider's employment. (ORC Ann. 3963.06).
- b) The credentialing process for a Medicaid-managed care plan starts when the provider submits a credentialing form and the provider's national provider number is issued by the Centers for Medicare and Medicaid Services. (ORC Ann. 3963.06).
- c) The requirement that the credentialing process be completed within the 90 day period specified in section 7A does not apply to a contracting entity if a provider that submits a credentialing form to the contracting entity is a hospital. (ORC Ann.3963.06).
- d) Any communication between the provider and the contracting entity must be electronically, by facsimile, or by certified mail, with return receipt requested. (ORC Ann. 3963.06).
- e) If the state medical board or its agent has primary source verified the medical education, graduate medical education, and examination history of the physician, or the status of the physician with the educational commission for foreign medical graduates, if applicable, the contracting entity may accept the documentation of primary source verification from the state medical board's website or from its agent and is not required to perform primary source verification of the medical education, graduate medical education, and examination history of the physician or the status of the physician with the educational commission for foreign medical graduates, if applicable, as a condition for initially credentialing or recredentialing the physician. (ORC Ann. 3963.06).

Health plans doing business with the State of Ohio are prohibited from using any off-shore resources. This would include credentialing and recredentialing functions. (Executive Order 2011-12K).

Facility credentialing in Ohio requires use of a state-mandated facility application.

Ohio UnitedHealthcare Community Plan Requirements²⁸

Additional requirements for verification of sanctions on Practitioners and Facilities including but not limited to: Office of the Inspector General List of Excluded Individuals and Entities and National Practitioner Data Bank, OH Department of Job and Family Services website.

²⁸ Requirements of state Medicaid contract

Oklahoma

Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs) are required to:

1. Accept the Department of Health Uniform Application for credentialing for all health care practitioners and permitted to require supplemental information. (63 Oklahoma (OK) Stat. 1-106.2).
2. Make information on criteria available to provider and provide applicant with a checklist of material required in the application process.
3. Notify practitioner within 10 days of receipt if application is incomplete, specifying the portion of application that is at issue.
4. Initiate credentialing process within seven days when application is complete.
5. Shall complete the credentialing process within 45 days upon receipt of the primary source verification and malpractice history on a “clean application.” A clean application means:
 - a) There is no defect, misstatement of facts, improprieties, lack of any required substantiating documentation, or particular circumstance requiring special treatment that impedes prompt credentialing or recredentialing; and
 - b) Professional liability carriers are required to respond to inquiries from health benefit plans within 21 days; the OK State Insurance Commissioner may assess a penalty against a professional liability carrier that fails to respond to a health benefit plan within the 21 day time frame.
6. Permitted to extend credentialing/recredentialing process for 60 days if unable to credential/recredential due to application not being “clean.”
 - a) If still awaiting documentation at the end of the 60-day extension, required to notify practitioner by certified mail of reason for delay.
7. Practitioner may request an extension of the 60-day period but must do so within 10 calendar days; otherwise the application shall be deemed withdrawn.
8. Under no circumstances shall the entire process exceed 180 calendar days.

Rev 07/2011, 08/2011, 03/2012, 11/2012, 11/2013, 5/2014, 10/2014, 3/2015, 08/2015, 12/2015, 03/2016, 06/2016, 11/2016, 2/2017, 6/2017, 11/2017, 01/2018, 07/2018, 10/2018, 01/2019

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Oregon

Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs) are required to:

1. Credential providers, but no specific credentialing requirements identified. (Oregon Revised Statutes sections 743.918(2); Oregon Administrative Rules sect. 836-053-1170(1)(c)(B)).
2. Accept the Oregon Practitioner Credentialing and Recredentialing Applications.
(Oregon Administrative Rules 333-505-0007 and 409-045-0000)

The Oregon Credentialing App can be found at the following Oregon.gov link: <http://www.oregon.gov/oha/HPA/OHIT-ACPCI/Documents/2012credappglossary.pdf>

3. Approve or reject a provider credentialing application within 90 days of receipt of a complete application containing all required credentialing information.
(Oregon Revised Statutes 743.918(2))

Rev 07/2011, 08/2011, 03/2012, 11/2012, 11/2013, 5/2014, 10/2014, 3/2015, 08/2015, 12/2015, 03/2016, 06/2016, 11/2016, 2/2017, 6/2017, 11/2017, 01/2018, 07/2018, 10/2018, 01/2019

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Pennsylvania

Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs) are required to include data from quality improvement activities at the time of recredentialing. (28 PA Code 9.761).

All individual contracted providers are subject to UnitedHealthcare's credentialing and recredentialing process per the current UnitedHealthcare Credentialing Plan in order to be considered participating in the provider network. UnitedHealthcare does not have a credentialing requirement for non-participating providers. (28 PA Code 9.763)

Upon written request, a UnitedHealthcare shall disclose relevant credentialing criteria and procedures to health care providers that apply to become participating providers or who are already participating. (28 PA Code 9.761)

UnitedHealthcare shall submit a report to the Pennsylvania Department of Health regarding its credentialing process every 2 years. The report shall include the following:

1. The number of applications made to the plan.
2. The number of applications approved by the plan.
3. The number of applications rejected by the plan.
4. The number of providers terminated for reasons of quality.

The next report will be due in 2020. (28 PA Code 9.761)

UnitedHealthcare shall not exclude or terminate a health care provider from participation in the plan due to any of the following:

1. The health care provider engaged in any of the following activities:
 - a) Advocating for medically necessary and appropriate health care consistent with the degree of learning and skill ordinarily possessed by a reputable health care provider practicing according to the applicable legal standard of care.
 - b) Filing a grievance pursuant to the procedures set forth in this article.
 - c) Protesting a decision, policy or practice that the health care provider, consistent with the degree of learning and skill ordinarily possessed by a reputable health care provider practicing according to the applicable legal standard of care, reasonably believes interferes with the health care provider's ability to provide medically necessary and appropriate health care.
2. The health care provider has a practice that includes a substantial number of patients with expensive medical conditions.
3. The health care provider objects to the provision of or refuses to provide a health care service on moral or religious grounds. (28 PA Code 9.761)

UnitedHealthcare's credentialing policies shall comply with 40 P.S. §991.2121. and 28 PA Code 9.761, 762 and 763.

Pennsylvania UnitedHealthcare Community Plan Requirements²⁹

1. The Medicaid PromiseID is required for network participation, but is not to be considered a credentialing decision-making element in the credentialing file process.
2. Assessment of Americans with Disabilities Act (ADA) compliance required as part of initial credentialing for primary care physicians (PCP) and dentists.
3. Certified Registered Nurse Practitioners, Certified Registered Midwife or physician's assistant, functioning as part of a PCP team must submit a copy of collaborative agreement with a physician.

²⁹ Requirements of state Medicaid contract.

4. Additional requirements for verification of sanctions on Practitioners and Facilities including but not limited to the Office of the Inspector General List of Excluded Individuals and Entities (OIG-LEIE) and the General Services Administration System for Awards Management (GSA-SAM) (the successor to the Excluded Parties List System (EPLS)) and State Medicaid MediCheck database.
5. Federal database check on Practitioners and Facilities of the National Plan and Provider Enumeration System (NPPES)
6. Credentialing must be completed within sixty (60) days of receipt of the application packet if the information is complete.
7. Adherence to the Principles of Ethics of the American Medical Association, the American Osteopathic Association or any appropriate professional organization involved in a multidisciplinary approach.
8. PCP qualifications: evidence of continuing professional medical education³⁰
9. Facility credentialing may include Pediatric Residential Care Centers.

³⁰ Criteria are covered under State Board of Medicine – Chapter 16 State Board of Medicine General Provisions

Rev 07/2011, 08/2011, 03/2012, 11/2012, 11/2013, 5/2014, 10/2014, 3/2015, 08/2015, 12/2015, 03/2016, 06/2016, 11/2016, 2/2017, 6/2017, 11/2017, 01/2018, 07/2018, 10/2018, 01/2019

Insurance and/or HMO regulations apply to all Commercial, Medicare and Medicaid products/health plans sold in each applicable state.

Insurance coverage provided by UnitedHealthcare Insurance Company or its affiliates. Health plan coverage provided by UnitedHealthcare of Arizona, Inc.; UnitedHealthcare of California, UnitedHealthcare of Colorado, Inc.; UnitedHealthcare of Oregon, Inc.; UnitedHealthcare of Utah, Inc.; and UnitedHealthcare of Washington, Inc. or other affiliates. Administrative services provided by United HealthCare Services, Inc. or its affiliates.

Puerto Rico

No additional credentialing requirements.

Rev 07/2011, 08/2011, 03/2012, 11/2012, 11/2013, 5/2014, 10/2014, 3/2015, 08/2015, 12/2015, 03/2016, 06/2016, 11/2016, 2/2017, 6/2017, 11/2017, 01/2018, 07/2018, 10/2018, 01/2019

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Rhode Island³¹

1. When Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs) deny a professional provider application, they are required to send written notification of all reasons for the denial within 60 days of receipt of the completed and verified application. (216 Code of RI Rules sect. 40-10-21.7(L).) [Please note the 45-day turn around time required below effective Jan. 1, 2018.]
2. When a health plan terminates a provider agreement, it is required to offer appeal rights. (216 Code of RI Rules sect. 40-10-21.7(L).)
3. Both Drug Enforcement Administration Certificate (DEA) and State -Controlled Dangerous Substances Certificate required.³² (216 Code of RI Rules sect.40-10-21.7(G)(2)(c)(4).)
4. If any health plan responsibility, in whole or in part, is delegated to another organization/agent, the health plan shall maintain oversight and accountability for all delegated activity through a formal agreement describing the delegated function(s) and oversight program. Health plans may not sub-delegate the responsibility of oversight. (216 Code of RI Rules sect.40-10-21.4(F).)
Effective Jan 1, 2018 for “health care entities” (insurers and HMOs) and health plans based on RI General Laws, Chapters 27-18-83 and 27-41-87.
5. Required to issue a decision no later than 45 days after receipt of a complete credentialing application. Required to establish written standard defining what elements constitute a complete credentialing application, make the standard available on company website, and distribute standard with written version of the credentialing application. (RI General Laws, Chapters 27-18-83 and 27-41-87, effective Jan. 1, 2018.)
6. Required to respond to inquiries from applicants regarding status of a credentialing application as follows: (a) provide automated application status updates at least once every 15 days, informing applicant of any missing application materials until application deemed complete; (b) inform applicant within five (5) business days that the credentialing application is complete; and (c) if credentialing application is denied, notify provider in writing and note any and all reasons for the denial. (RI General Laws, Chapters 27-18-83 and 27-41-87, effective Jan. 1, 2018.)
7. Effective date for billing privileges shall be the next business day following approval of the credentialing application. (RI General Laws, Chapters 27-18-83 and 27-41-87, effective Jan. 1, 2018.)
8. For credentialing applications received from resident graduates, required to offer transitional/conditional approval process such that a resident graduate who has submitted an otherwise complete application and met all other criteria may be conditionally approved effective upon successful graduation from training program. (RI General Laws, Chapters 27-18-83 and 27-41-87, effective Jan. 1, 2018.)

Rhode Island UnitedHealthcare Community Plan Requirements³³

Primary Care Qualifications Attestation for Advanced Practice Practitioners Certified Nurse Practitioners, and/or Physician Assistants. Advanced Practice Practitioners who wish to become PCPs shall submit documentation of evidence of a collaborative relationship with a Primary Care Physician, in which this physician agrees to share responsibility for the care of patients, and particularly assume responsibility for components of care which are beyond the scope of practice and/or expertise of the Advanced Practice Practitioner. The designated physician shall also agree to collaborate with the Advanced Practice Practitioner to ensure that members receive specialty and other referrals as necessary.

³¹ Credentialing files must contain copies of license, DEA, CDS or copies of verification sources

³² National Committee for Quality Assurance primary source verification requirements that apply to both documents.

³³ Requirements of the State Medicaid Contract.

South Carolina

No additional credentialing requirements.

Rev 07/2011, 08/2011, 03/2012, 11/2012, 11/2013, 5/2014, 10/2014, 3/2015, 08/2015, 12/2015, 03/2016, 06/2016, 11/2016, 2/2017, 6/2017, 11/2017, 01/2018, 07/2018, 10/2018, 01/2019

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South Dakota

- If a health insurer (or other entity credentialing on its behalf) receives a request from a health care professional for a credentialing application, then the insurer or entity is required to send the application form to the professional within 10 business days, unless the application is available electronically on a public website.
- Within 90 days of receiving a complete credentialing application, the health insurer (or other entity credentialing on its behalf) must provide the applicant with electronic or written notice of its determination.
 - If an incomplete application is received, the insurer or entity must notify the health care professional of such as soon as possible, but no more than 30 days after receipt, and the notification must itemize everything still needed to make the application complete. The insurer or entity may request additional information if the information provided is inaccurate, incomplete, or unclear.
- The insurer or entity may take additional time beyond the 90 days if a special review (as defined) is require
 - “Special Review” means a supplemental review of a health care professional’s completed application for credentialing or change request by a health insurer or other entity responsible for credentialing of health care professionals necessitated by credible evidence received by a health insurer or other entity responsible for credentialing of health care professionals as it relates to investigation of the following: action taken against the applicant’s licensure status, action taken against the applicant’s professional society status, verified complaints to facilities, or licensing agency regarding the applicant; the applicant’s non-completion of training programs; a criminal proceeding brought against the applicant a malpractice claim brought against the applicant; loss of a Drug Enforcement Administration certificate or state-controlled substance certificate; loss of a Medicare or Medicaid certification status; or involuntary termination of credentialing by a different health insurer.

2014 HB 1157.

Tennessee

Insurers, Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs) are:

1. Required to accept the Council for Affordable Quality Healthcare (CAQH) provider application in addition to the health insurance entity's own application. (Tennessee (TN) Code Ann. 56-7-1009).
2. If health insurance entity is a participating organization with CAQH, it's required to accept either the electronic application or a paper application. (TN Code Ann.56-7-1009)
3. Required to respond within 90 days to providers who submit "clean" CAQH application. A "clean" CAQH application means there is no defect, misstatement of facts, improprieties, lack of required substantiating documentation or particular circumstance requiring special treatment that impedes prompt credentialing. (TN Code Ann. 56-7-1001).
4. Unless otherwise required by a national accrediting body, a health insurance entity shall accept and begin processing a completed credentialing application as early as ninety (90) calendar days before the anticipated employment start date of the health care provider. (TN Code Ann. 56-7-1009(b).)
5. Cannot require activation of malpractice coverage prior to effective date of participation. (TN Code Ann. 56-7-1001(c)).
6. For HMOs only: recredentialing procedure to include data from quality improvement activities. (Tenn. Comp R & Regs. R. 1200-8-33-06(12))
7. For HMOs only: required to monitor and evaluate delegated credentialing activities on an ongoing basis. (Tenn Comp. R & Regs. R. 1200-8-33-06(12)).
8. For HMOs only: the attestation must not be older than 180 calendar days at the time of the credentialing decision. (Tenn. Comp. R. & Regs. R. 1200-8-33-06(2)).
9. For new provider applicants joining a participating medical group,;
 - a) Provide group with list of all information and supporting documentation required for credentialing application of a new provider applicant to be considered complete.
 - b) Notify new provider applicant in writing of status of credentialing application no later than five (5) business days of receipt of the application. Notice shall indicate if application is complete or incomplete, and if incomplete, shall indicate information or documentation needed to complete the application.
 - c) If application is incomplete and new provider applicant submits additional information or documentation to complete the application, health insurance entity shall notify the new provider applicant in writing of the status of the credentialing application no later than five (5) business days of receipt of the additional information or documentation.
 - d) Notify new provider applicant of the results of the credentialing application within ninety (90) days after notification from the health insurance entity that the application is complete.
 - e) If the new provider applicant fails to submit a complete credentialing application within thirty (30) calendar days of notice of an incomplete application, then the application is deemed incomplete and credentialing is discontinued. (TN Code Ann. 56-7-1001(f).)

Tennessee UnitedHealthcare Community Plan Requirements³⁴

1. The Contractor shall completely process credentialing applications within (30) calendar days of receipt of a completed credentialing application, including all necessary documentation and attachments, and a signed provider agreement. Completely process shall mean that the Contractor shall review, approve and load approved applicants to its provider files in its claims processing system or deny the application and assure that the provider is not used by the Contractor.
2. Federal database checks on Practitioners and Facilities of the National Plan and Provider Enumeration System (NPPES) prior to credentialing/recredentialing decision.
3. Additional query of TennCare Terminated Provider List is required for Practitioners and Facilities: <https://www.tn.gov/tenncare/topic/terminated-provider-list>

³⁴ Requirements of the State Medicaid Contract.

Texas

The standards set out in section four of the National Credentialing Plan set the baseline credentialing standards for licensed independent practitioners (LIP) and components in all markets. In addition to these national standards, in Texas, compliance is also required with the following state laws/regulations:

- **Standardized Credentialing Form:** Physicians, Advance Practice Nurses and Physician Assistants. Hospitals and Health Maintenance Organizations (HMOs) are required to use the form. (TX Ins. Code 1452.052, 28 TX Adm. Code 21.3201).
- **HMO Credentialing Files:** Credentialing files are included in the list of documents required to be available at the HMO offices in TX. (28 TX Adm. Code 11.303 (c)(11))
- **HMO Quality Improvement Program:** HMOs are required to implement a documented process for selection and retention of contracted physicians and providers. The HMO's credentialing process, and that of the HMO's delegate where credentialing is delegated, must comply with National Committee for Quality Assurance (NCQA) standards to the extent the NCQA standards do not conflict with TX state requirements. (28 TAC section 11.1902(4) and (7)).

"The HMO is required to have procedures for detecting deficiencies **subsequent to the initial site visit...**" (Emphasis added. 28 TAC section 11.1902(5)(A)).

The HMO Medical Director [28 TAC 11.1606] is required to:

- Be licensed in Texas (§11.1606 (c)(1))
- Reside in Texas (§11.1606 (c)(2))
- Demonstrate active involvement in all quality management activities (§11.1606 (c)(4))
- Be subject to HMO's credentialing requirements (§11.1606 (c)(5))

HMOs are required, during the annual application period only, to respond to physician and provider applications for participation within 90 days of receipt of the application for participation. (28 TX Adm. Code 11.1402(c)). Notification to physician or provider will be given in writing.

Preferred Provider Organizations (PPOs) Provider Contracting Requirements

(28 TX Adm. Code 3.3706):

- All LIPs and components must be eligible to apply and be afforded a fair, reasonable and equitable opportunity to become a preferred provider.
- Notify annually all LIPs in the service area of the opportunity to apply to participate. The notice may be made by publication or individual writings to all affected LIPs.
- Designation as a preferred provider may not be unreasonably withheld, but the PPO may reject an application on the basis of sufficient qualified providers already in the network.
- Provide the specific reason for denials to LIPs and components.
- All denials of LIP initial credentialing applications must offer the right to a review of the denial by an advisory review panel.
 - The advisory review panel shall be composed of three or more participating LIPs in the service area, at least one of whom is an LIP in the same or similar specialty as the applicant.
 - The PPO may make a determination that is contrary to the recommendation of the advisory review panel.
 - The PPO is required to provide a written explanation of denied applications.
 - Upon request of the LIP, the advisory panel recommendation must be provided.
- Notices of terminations of agreements with LIPs and components must include the reason for the termination.

Rev 07/2011, 08/2011, 03/2012, 11/2012, 11/2013, 5/2014, 10/2014, 3/2015, 08/2015, 12/2015, 03/2016, 06/2016, 11/2016, 2/2017, 6/2017, 11/2017, 01/2018, 07/2018, 10/2018, 01/2019

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- For terminations of LIP agreements, the PPO is required to offer review by an advisory review panel, following the same procedure noted above, except in cases of:
 - Imminent harm to patient health, or
 - Action by any state licensing board which impairs an LIP’s ability to practice, or
 - Fraud or malfeasance.

HMOS and PPOs (TX Ins. Code 1452.103 – effective September 2007)

When an applicant physician who joins a medical group, medical school or teaching hospital that already participates in the managed care plan’s network, the applicant physician is considered eligible for “expedited credentialing” when the managed care plan has:

- Verified that the applicant physician is licensed in good standing with the Texas Medical Board, and
- Determined that all credentialing information necessary to initiate the credentialing process for the applicant physician has been submitted.

During expedited credentialing:

- The managed care plan is not obligated to list the applicant physician in the provider directory, and
- The applicant physician is not considered to be a primary care physician for selection by HMO members until the full credentialing process is completed.

Upon completion of the managed care plan’s standard credentialing process:

- The plan may reject the applicant physician’s application if they do not meet standard credentialing requirements, and
- Managed care plans are explicitly protected from liability for damages based on the expedited credentialing process of applicant physicians.

Texas UnitedHealthcare Community Plan Requirements³⁵

1. Inclusion of data from quality improvement activities at the time of recredentialing.
2. Additional requirements for verification of sanctions on Practitioners and Facilities including but not limited to the Office of the Inspector General List of Excluded Individuals and Entities (OIG-LEIE) and the General Services Administration System for Awards Management (GSA-SAM) (the successor to the Excluded Parties List System (EPLS)) and the Texas Office of the Inspector General List of Medicaid Exclusions:oig.hhsc.state.tx.us/Exclusions/Search.aspx.
3. The MCO must complete the credentialing process for a new provider and its claims system must be able to recognize the provider as a Network Provider no later than 90 calendar days after receipt of a completed application.
4. If an application does not include all required information, the MCO must provide the provider with written notice of all missing information no later than 5 Business Days after receipt.
5. If a provider qualifies for expedited credentialing the claims system must be able to recognize the provider as a Network Provider no later than 30 calendar days after receipt of a completed application even if the MCO has not yet completed the credentialing process. (The MCO must comply with requirements of Texas Chapter 1452 Sub-chapter C, D, and E regarding expedited credentialing and payment of physicians, podiatrists and therapeutic optometrists who have joined established medical groups or professional practices that are already contracted with the MCO.)

³⁵ Requirements of the State Medicaid Contract.

New applicants who are joining a participating network provider group that is already contracted to provide services to Medicaid beneficiaries are required to submit all required documentation and information for the credentialing process to be initiated.

Upon submission of the required documentation and information, the managed care organization is required to treat the applicant as if the applicant were in-network.

If the applicant does not pass credentialing, the managed care organization may not recover any payments made prior to the completion of credentialing.

If the applicant does not pass credentialing and the managed care organization determines that the applicant made fraudulent claims in the credentialing application, the managed care organization may recover the entire amount of any payment made to the applicant.

(TX Govt Code section 533.0064.)

Utah

Pursuant to Utah Code Annotated section 31A-45-304, managed care plans are:

1. Required to establish credentialing criteria for participating providers, which must be filed with the state and made available to any provider upon request.
2. Required to make a decision on the provider application within 120 days of receipt of the application and all necessary information.
3. Prohibited from rejecting applicants, or terminating participation, based solely on the provider's staff privileges at a general acute care hospital not under contract with the managed care organization.

Rev 07/2011, 08/2011, 03/2012, 11/2012, 11/2013, 5/2014, 10/2014, 3/2015, 08/2015, 12/2015, 03/2016, 06/2016, 11/2016, 2/2017, 6/2017, 11/2017, 01/2018, 07/2018, 10/2018, 01/2019

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Vermont

Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs).

(Code of VT Rules 21-040-010 et. seq.)

- The Medical Director, required to be licensed in VT, is responsible for and required to participate in provider credentialing verification process.
- 1. Primary source verification is required for the following elements for initial credentialing: Professional Liability Insurance certificate from the carrier, status of hospital privileges, DEA Certificate or State Controlled Dangerous Substances Certificate require primary source verification, work history.³⁶
- 2. Primary source verification of Drug Enforcement Administration (DEA) Certificate or State Controlled Dangerous Substances Certificate from the carrier for recredentialing.
- 3. Recredentialing process needs to include performance appraisal of provider, review of data from member complaints, and results of quality reviews, utilization management reviews and member satisfaction surveys.

Vermont adopted the Council on Affordability and Quality Healthcare (CAQH) credentialing form as its Uniform Credentialing Application. (18 VT Statutes Annotated 9408(a); 192 VT Government Register 43).

1. Health care insurers and HMOs are required to notify providers of deficiencies on completed applications within 30 business days of receipt of the application by the insurer.
2. Health care insurers and HMOs are required to act upon and finish the credentialing process within 60 calendar days of receipt of a completed application. An application is considered complete once the insurer has received all information and documentation necessary to make its credentialing decision. (18 VT Statutes Annotated 9408(a).)

³⁶ A copy of professional liability declaration sheet will serve as evidence of primary source verification. A review of the attested credentialing application will serve as primary source verification of work history.

Virgin Islands (U.S.)

No additional credentialing requirements.

Rev 07/2011, 08/2011, 03/2012, 11/2012, 11/2013, 5/2014, 10/2014, 3/2015, 08/2015, 12/2015, 03/2016, 06/2016, 11/2016, 2/2017, 6/2017, 11/2017, 01/2018, 07/2018, 10/2018, 01/2019

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Virginia

Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs) are required to:

1. Notify applicant within 60 days of receipt, and if information is missing rendering the application incomplete. (12 Virginia Administrative Code 5-408-170(D)(6)).
2. Complete credentialing process within 90 days of receipt of additional information. (12 Virginia Administrative Code 5-408-170(D)(6)).
3. Complete credentialing process within 120 days for clean applications. (12 Virginia Administrative Code 5-408-170(D)(6)).
4. Complete initial credentialing process before: applicant enters into contract with the health plan, begins to see enrollees, or is listed in provider directory. (12 Virginia Administrative Code 5-408-170(F)).
5. Include data from quality improvement activities at recredentialing. (12 Virginia Administrative Code 5-408-170(G)(5)).
6. Active medical staff privileges or admitting privileges are waived for podiatrists provided that the podiatrist has a delineation of privileges that enables such podiatrist to perform the type of services that are covered by the PPO or HMO at a designated hospital or hospitals. (Va. Code Ann. § 38.2-3407.6).

Virginia UnitedHealthcare Community Plan Requirements

Inclusion of data from quality improvement activities at the time of recredentialing.

Federal database checks on Practitioners and Facilities of the National Plan and Provider Enumeration System (NPPES), the Office of Inspector General List of Excluded Individuals/Entities (OIG/LEIE) and the General Services Administration's System for Awards Management (GSA/SAM) (the successor to the Excluded Parties List System (EPLS)) prior to credentialing/rec credentialing decision.

Database query of the National Practitioner Data Bank (NPDB) during credentialing and rec credentialing

The Contractor and its network providers shall comply with all applicable Federal and State laws assuring accessibility to all services by individuals with disabilities pursuant to the Americans with Disabilities Act (ADA) (28 CFR § 35.130) and Section 504 of the Rehabilitation Act of 1973 (29 USC § 794) and maintain capacity to deliver services in a manner that accommodates the needs of its Members.

Washington D.C.

Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs) are required to accept the district's uniform credentialing form for credentialing and recredentialing.

(D.C. Code sections 31-3252 and 31-3251; Code of D.C. Municipal Regulations sections 26-4201 and 26-4299.)

Rev 07/2011, 08/2011, 03/2012, 11/2012, 11/2013, 5/2014, 10/2014, 3/2015, 08/2015, 12/2015, 03/2016, 06/2016, 11/2016, 2/2017, 6/2017, 11/2017, 01/2018, 07/2018, 10/2018, 01/2019

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Washington

(Washington Administrative Code sections (WAC 284-170-411.) (WAC 284-170-390.) (Rev. Code WA 48.165.005, 48.165.010 & 48.165.035.)

1. Effective June 1, 2018, health carriers shall use the uniform electronic process (the database) to accept and manage credentialing applications from health care providers. (Rev. Code WA 48.43.750.)
 - a) Determinations to approve or deny a credentialing application shall be made no later than 90 days after receiving a completed credentialing application.
 - b) Effective June 1, 2020, approval or denial determinations made by the health carrier must average no more than 60 days.
 - c) Does not apply to health care entities that utilize credentialing delegation arrangements in the credentialing of their health care providers with health carriers.
2. For health plans issued or renewed on or after Jan. 1, 2016 but before Jan. 1, 2017, health plans that delegate credentialing agreements to contracted health care facilities must accept credentialing for pharmacists employed or contracted by those facilities.
(Rev. Code WA 48.43.XXX (3) – Senate Bill 5557(2015).)

Washington UnitedHealthcare Community Plan³⁷

Federal database checks on Practitioners and Facilities of the National Plan and Provider Enumeration System (NPPES), the Office of Inspector General List of Excluded Individuals/Entities (OIG/LEIE) and the General Services Administration's System for Awards Management (GSA/SAM) (the successor to the Excluded Parties List System (EPLS)) prior to credentialing/recredentialing decision.

Additional query of WA Provider Termination and Exclusion List is required for Practitioners and Facilities: <http://www.hca.wa.gov/billers-providers/apple-health-medicaid-providers/provider-termination-and-exclusion-list>

Contractor must notify providers within fifteen (15) calendar days of the credentialing committee decision.

³⁷ Requirements of the State Medicaid Contract.

West Virginia

W. VA. CSR § 114-53-4 Requirements of a Quality Assurance Program:

4.1. A Health Maintenance Organization (HMO) shall develop a quality assurance program which adheres to all applicable state and federal laws, federal regulations and state rules.

a. An HMO that has obtained full accreditation or equal status from a nationally recognized accreditation and review organization approved by the commissioner pursuant to West Virginia Code §33-25A-17a is deemed to be in compliance with this rule.

“Credentialing entity” means any health care facility, payor or network that requires credentialing of health care practitioners; “credentialing entity” has the same meaning ascribed to “health care entity” in W. Va. Code of St. Rules 64, 114CSR3.4. (W. VA. CSR 64-89B-2.4)

“Health Care Practitioner” or “practitioner” means a health care provider who is licensed, certified, or otherwise authorized to provide health care services, as designated by the Secretary and Commissioner to be subject to the uniform credentialing and recredentialing forms. (W. VA. CSR 64-89B-2.6)

Shall use the uniform credentialing form developed by the committee for credentialing health care practitioners and the uniform recredentialing form developed by the committee for recredentialing health care practitioners. (W. Va. CSR § 64-89-4) Applications can be found at <http://www.wvinsurance.gov/UniformCredentialing.aspx>

A health care entity may request information in addition to the information provided in the uniform credentialing or uniform recredentialing forms. A request for additional information may not require repetition of the information required in, or substitute another form for, the uniform credentialing or uniform recredentialing forms. Additional information shall be requested by the health care entity on supplemental sheets attached to the uniform forms. (W. Va. CSR § 64-89-4.4)

When the uniform credentialing form or uniform recredentialing form is amended as provided in Section 5 of this rule, all health care entities shall use the amended uniform forms to credential or recredential health care practitioners. (W. VA. CSR 64-89-4.5)

Any credentials data collected or obtained by a health care entity during the credentialing or recredentialing process shall constitute confidential peer review information, as provided by W. Va. Code §30-3C-3, and shall not be disclosed by the health care entity except as provided by law. (W VA CSR § 64-89-6).

When a contract with a statewide CVO has been executed by the state of WV, the following paragraph will apply. As of March 2018, the WV Department of Insurance has advised that the state-wide CVO has not yet been established.

Except as provided in subsection 8.3 of this section, during the third year after the completion of a practitioner’s initial credentialing, each practitioner is subject to recredentialing by the last day of the practitioner’s birth month and by the same date every third year thereafter. (W. Va. CSR § 64-89B-8.1) The CVO shall be responsible for notifying each practitioner of their recredentialing date in a timely manner. (W. Va. CSR § 64-89B-8.2)

Nothing in this rule may be construed to prohibit a health care entity from delegating credentialing or recredentialing activities to another entity, such as a certified verification organization, as long as the entity to whom the activities have been delegated follows the requirements of this rule. (W. Va. CSR § 64-89-7)

Wisconsin

No additional credentialing requirements.

Wisconsin UnitedHealthcare Community Plan Requirements³⁸

Inclusion of data from quality improvement activities at the time of recredentialing.

³⁸ Requirements of the State Medicaid Contract.

Wyoming

Health Maintenance Organizations (HMOs) are required to credential licensed individual practitioners and hospitals, but no specific credentialing requirements identified.

(Wyoming Statutes Annotated sections 26-34-108(b)(ii)(G)).

Rev 07/2011, 08/2011, 03/2012, 11/2012, 11/2013, 5/2014, 10/2014, 3/2015, 08/2015, 12/2015, 03/2016, 06/2016, 11/2016, 2/2017, 6/2017, 11/2017, 01/2018, 07/2018, 10/2018, 01/2019

Insurance and/or HMO regulations apply to all Commercial, Medicare and Medicaid products/health plans sold in each applicable state.

Insurance coverage provided by UnitedHealthcare Insurance Company or its affiliates. Health plan coverage provided by UnitedHealthcare of Arizona, Inc.; UnitedHealthcare of California, UnitedHealthcare of Colorado, Inc.; UnitedHealthcare of Oregon, Inc.; UnitedHealthcare of Utah, Inc.; and UnitedHealthcare of Washington, Inc. or other affiliates. Administrative services provided by United HealthCare Services, Inc. or its affiliates.

Federal Requirements for Medicare Participation³⁹

UnitedHealthcare's Credentialing plan for Medicare and Medicaid managed care plans adheres to managed care standards at 42 CFR §438.214 and 42 CFR §422.204. This addendum outlines only those additional requirements that are not already covered within the body of the Credentialing plan.

1. The information collected and verified must be no more than 180 calendar days old at the time of the Credentialing Committee decision.
2. The provider must not be excluded or debarred from participation in Medicare via a query of the General Services Administration/SAM database.
3. Delegation agreements must address Medicare Advantage (MA) contracting and delegation requirements, including but not limited to a requirement to comply with all applicable MA credentialing requirements. (See 42 CFR 422.504(i) and Medicare Managed Care Manual, Chapter 11, Sections 100.5 & 110).
4. Verification that licensed individual practitioners have not opted out of participation with Medicare.
5. Credentialing required for additional facility types as outlined in the Credentialing Plan (Attachment C), including but not limited to credentialing Federally Qualified Health and Rural Health Clinics as facilities.
6. Those facilities listed in Attachment C of the Credentialing Plan must have a provider agreement with CMS (e.g., Medicare CMS certification). See also Medicare Managed Care Manual, Chapter 6.

Additional information available at:

[cms.gov/Manuals/IOM/list.asp](https://www.cms.gov/Manuals/IOM/list.asp)

- Medicare Managed Care Manual, Chapter 6.
- Medicare Program Integrity Manual, Chapter 15
- Medicare Benefit Policy Manual, Chapter 15, Section 40

<http://www.npdb.hrsa.gov/>



³⁹ 42 CFR 422.204 and 42 CFR 438.214 applies to all Medicare and Medicare/Medicaid dual eligible products

Rev 07/2011, 08/2011, 03/2012, 11/2012, 11/2013, 5/2014, 10/2014, 3/2015, 08/2015, 12/2015, 03/2016, 06/2016, 11/2016, 2/2017, 6/2017, 11/2017, 01/2018, 07/2018, 10/2018, 01/2019

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