DMEPOS ancillary provider inquiry questionnaire

Required steps:
1. Fill out digital PDF
2. Save/download completed form
3. Email completed form with required documentation to dmeposnetwork@uhc.com

This form is to be completed to request participation in UnitedHealthcare DMEPOS Network

1. New agreement for an eligible DMEPOS provider who meets the following criteria:
   - Provider is located in a state with Any Willing Provider (AWP) requirements
   - Provider fills a documented geographic access gap for specific DMEPOS services
   - Provider offers covered services that are not available through the existing network
2. Current network DMEPOS provider requesting renegotiation or adding markets/LOB to an existing agreement

Provider contact information

Contact name: Email address:

Provider information

Tax ID number	NPI	Associated legal name	Legal DBAs affiliated with provider

Servicing markets:

Provider address:

City: State: Zip: Website:

Provider quality attestation

My initials attest that the requester is a Medicare-certified provider in good standing. Initial here

Requester is accredited by the following for services being requested. Provide copy of accreditation

Accreditation Commission for Health Care
Respiratory, Complex Rehab, Custom Orthotics/Prosthetics, Therapeutic Shoes, Ocular prostheses

American Board for Certification in Orthotics & Prosthetics, Inc.
Respiratory, Complex Rehab, Custom Orthotics/Prosthetics, Therapeutic Shoes, Ocular prostheses

Board of Certification/Accreditation International
Respiratory, Complex Rehab, Custom Orthotics/Prosthetics, Therapeutic Shoes, Ocular Prostheses

Commission on Accreditation of Rehabilitation Facilities (CARF)
Respiratory, Complex Rehab, Custom Orthotics/Prosthetics, Therapeutic Shoes, Ocular Prostheses

Community Health Accreditation Program (CHAP)
Respiratory, Complex Rehab, Custom Orthotics/Prosthetics, Therapeutic Shoes, Ocular Prostheses

HealthCare Quality Association on Accreditation
Respiratory, Complex Rehab, Custom Orthotics/Prosthetics, Therapeutic Shoes, Ocular Prostheses

United Healthcare

Provider quality attestation (cont.)

My initials attest that the requester is a Medicare-certified provider in good standing. Initial here
Requester is accredited by the following for services being requested. Provide copy of accreditation

National Association of Boards of Pharmacy
Respiratory, Breast Prosthetics, Therapeutic Shoes/Inserts
The Compliance Team, Inc.
Respiratory, Complex Rehab, Custom Orthotics/Prosthetics, Therapeutic Shoes, Ocular Prostheses
The Joint Commission
Respiratory, Complex Rehab, Custom Orthotics/Prosthetics, Therapeutic Shoes, Ocular Prostheses

Type of participation agreement requested

Check all that apply:

Commercial **Medicare** **Community Plan (Medicaid)** **State abbreviation** ___

Medicaid number

Medicare number

Existing network provider

Current contract termination date Current contract termination notice date
Current contracted fee schedule

Services provided

Identify the top 3 specialties and annual UnitedHealthcare claim volume (in thousands) for those specialties

Bone growth	$	**Negative pressure wound therapy**	$
Breast pump	$	**Orthotics**	$
Complex rehab	$	**Ostomy**	$
Continuous passive motion (CPM)	$	**Pneumatic compression**	$
Diabetic shoes	$	**Prosthetics**	$
Diabetic testing	$	**Respiratory**	$
DME & supplies	$	**Respiratory vest**	$
Dynamic splinting	$	**Speech generating device**	$
Enteral	$	**TENS**	$
Incontinence	$	**Urological**	$
Insulin therapy	$	**Other (specify)**	$

Attestation

I attest that the information submitted on this document to be true and correct.

Signature:

Printed name and title:

Date signed:

United Healthcare