Group/Organization Demographic Information Update

- The **My Practice Profile app** on Link lets you view, update and attest to the care provider demographic information UnitedHealthcare members see for your organization. Use the app to make demographic changes just one time, in one place — and get those updates into our systems more quickly. You can find instruction about updating your information at **UHCprovider.com/mypracticeprofile**.
- If you can't update demographic information online, use this form for practices with **two or more** care provider practitioners. For **single care provider practitioner updates**, please use the Care Provider Demographic Information Update form at **UHCprovider.com/mypracticeprofile**.
- Incomplete forms will not be processed.
- UnitedHealthcare uses current data and the updates you provide to publish accurate care provider directories. By submitting this form, **you are confirming that these are the only changes needed at this time**.
- Fields with an asterisk (*) are required for practitioners providing care under all UnitedHealthcare plans.
- If additional space is required, please include a separate roster with this form.
- A **W-9 form** is required when adding a new group, organization and practitioner, adding new tax ID numbers and making name changes.
- **Index: Section I** – Group/Organization Information

  Section II – Maintenance to Group/Organization Tax ID Numbers, Addresses, Contact Information

  Section III – Add Care Provider Practitioners to a Group/Organization

  Section IV – National Provider Identifier (NPI) Number Definitions and Requirements

  Section V – Sign and Submit

Section I – Group/Organization Information

Please include all updates to the group or organization. If you are adding a new group or organization, items with an asterisk (*) are required.

***Group/Organization Name:** _____

☐ This is a name change. *Attach a copy of the W-9 form for name changes.*

Previous Group/Organization Name: _____

Effective Date of Change (MM/DD/YYYY): _____

***Tax ID Number (TIN):** _____

Effective Date of Change (MM/DD/YYYY): _____

Group/Organization website: _____

Group/Organization email: _____

Group Medicare ID number: _____

UnitedHealthcare®

Group Medicaid ID number: _____

***National Provider Identifier (NPI) Number**

Refer to Section IV for details about NPI number requirements.

Is this group/organization an atypical provider?

☐ Yes. NPI is not required.

☐ No. *Complete the following NPI number information:

NPI Number: _____

NPI Number Taxonomy Code: _____

NPI Number Issue Date (MM/DD/YYYY): _____

Basis for NPI Number: _____

NPI Number Level of Information: _____

Section II – Maintenance to Group/Organization Tax ID Numbers, Addresses, Contact Information

Updating the TIN may require also updating the corresponding address. Please make the address changes on this form as needed and attach a copy of the W-9 for TIN additions, changes or updates to the TIN legal owner. Additional care providers may be submitted on a roster with the following information.

☐ **Tax ID Number (TIN) Change**

Old TIN: _____ New TIN: _____

Legal Owner of new TIN: _____

Effective Date (MM/DD/YYYY): _____

Old TIN: If the care provider is a PCP, please provide the name of a care provider for member reassignment:

PCP Name: _____

UnitedHealthcare will reassign members to the listed care provider when available. If we are unable to assign to your selected care provider, UnitedHealthcare will identify an acceptable replacement.

☐ **TIN Addition**

TIN: _____ Legal Owner of TIN: _____

Effective Date (MM/DD/YYYY): _____

☐ Applies to all care providers associated with the group/organization

☐ Applies to the following care providers only (list name and NPI number):

_____

☐ **TIN Maintenance**

TIN: _____ Legal Owner of TIN: _____

Effective Date (MM/DD/YYYY): _____

Telephone or Fax Number Update

Provide any additional telephone or fax updates on a separate roster and include the following information.

Update for TIN: _____

Address associated with this update: ☐ Billing ☐ Practice Location ☐ Mailing ☐ Credentialing

Street: _____ Suite/Other: _____

City: _____ State: _____ County: _____ ZIP+4: _____

☐ **Phone Number Update** ☐ Change ☐ Add only ☐ Delete only

Add phone: _____ Extension: _____

Delete phone: _____ Extension: _____

Publish this practice location phone number change or add in the UnitedHealthcare care provider directory as:

a. A UnitedHealthcare Community Plan participating care provider ☐ Yes ☐ No ☐ N/A

b. A UnitedHealthcare Medicare Advantage contracted care provider ☐ Yes ☐ No ☐ N/A

c. A UnitedHealthcare commercial participating care provider ☐ Yes ☐ No ☐ N/A

If you choose not to display the phone number in our directory, one of the following reasons must apply:

☐ Care provider is not active due to taking an extended leave of absence.

☐ Care provider is in the process of being removed from the UnitedHealthcare network.

☐ Care provider is under investigation for fraud, licensure or quality issues.

☐ Decline to publish care provider information because of one or more California-specific exemptions. Please attach a signed statement.

☐ The care provider is currently enrolled in the state's **Safe at Home program**.

☐ The care provider fears for their safety or their family's safety because of their affiliation with a health care service facility or because they provide health care services.

☐ This location, facility or any of its care providers, employees, volunteers or patients is or was the target of threats or acts of violence within the past year.

This telephone update is applicable to:

☐ All care providers associated with the group/organization

☐ The following care providers only (list name and NPI number):

_____

☐ **Fax Update** ☐ Change ☐ Add only ☐ Delete only

Add fax: _____ Delete fax: _____

This fax update is applicable to:

☐ All care providers associated with the group/organization

☐ The following care providers only (list name and NPI number):

_____

Address Update

☐ **Delete Address**

TIN: _____

Provide any additional addresses on a separate roster and include the following required information.

Address type: ☐ Billing ☐ Practice Location ☐ Mailing ☐ Credentialing

Street: _____ Suite/Other: _____

City: _____ State: _____ County: _____ ZIP+4: _____

Effective Date (MM/DD/YYYY): _____

This address update is applicable to:

☐ All care providers associated with the group/organization

☐ The following practitioners only (list name and NPI number):

_____

☐ **Add Billing, Mailing or Credentialing Address**

TIN: _____

Provide any additional addresses on a separate roster and include the following required information.

Address type: ☐ Billing ☐ Practice Location ☐ Mailing ☐ Credentialing

Street: _____ Suite/Other: _____

City: _____ State: _____ County: _____ ZIP+4: _____

Effective Date (MM/DD/YYYY): _____

This address update is applicable to:

☐ All care providers associated with the group/organization

☐ The following care providers only (list name and NPI number):

_____

Practice Location Address:

TIN: _____

☐ **Add New Address** ☐ **Update Current Address**

Additional practice location addresses to be added for the group/organization must be listed on a separate roster with all following required/applicable information.

Street: _____ Suite/Other: _____

City: _____ State: _____ County: _____ ZIP+4: _____

Effective Date (MM/DD/YYYY): _____

This address update is applicable to:

☐ All care providers associated with the group/organization

☐ The following care providers only (list name and NPI number):

_____

1. This is the primary practice location address. ☐ Yes ☐ No
2. The practice location address, for correspondence purposes, is: ☐ Primary ☐ Secondary ☐ None
3. Publish this location address in the UnitedHealthcare care provider directory as:
   a. A UnitedHealthcare Community Plan participating care provider ☐ Yes ☐ No ☐ N/A
   b. A UnitedHealthcare Medicare Advantage contracted care provider ☐ Yes ☐ No ☐ N/A
   c. A UnitedHealthcare commercial participating care provider ☐ Yes ☐ No ☐ N/A

   Only care providers who regularly practice at the specified location may be listed in the directory.

   If you choose not to display the address in our directory, one of the following reasons must apply:

   ☐ Care provider is not active due to taking an extended leave of absence.

   ☐ Care provider is in the process of being removed from the UnitedHealthcare network.

   ☐ Care provider is under investigation for fraud, licensure or quality issues.

   ☐ Decline to publish care provider information because of one or more California-specific exemptions. Please attach a signed statement.

   ☐ The care provider is currently enrolled in the state's **Safe at Home program**.

   ☐ The care provider fears for their safety or their family's safety because of their affiliation with a health care service facility or because they provide health care services.

   ☐ This location, facility or any of its care providers, employees, volunteers or patients is or was the target of threats or acts of violence within the past year.

4. National Provider Identifier (NPI) Number

   Please refer to Section IV for details about NPI number requirements.

   *NPI number associated with the practice location address (not required for atypical providers):
   _____ ☐ Not applicable

   NPI number issue date (MM/DD/YYYY) associated with the practice location address:

   _____

   NPI number taxonomy code associated with the practice location address:

   _____

5. *Primary specialty associated with this practice location address:

   _____

6. Additional specialty 1 associated with this practice location address:

   _____

   a. Additional specialty 1 effective date (MM/DD/YYYY): _____

7. Additional specialty 2 associated with this practice location address:

   _____

   a. Additional specialty 2 effective date (MM/DD/YYYY): _____

8. This location's expertise (if applicable) with individuals:
   - ☐ With physical disabilities
   - ☐ With chronic illness
   - ☐ With HIV/AIDS
   - ☐ With serious mental illness
   - ☐ Who are homeless
   - ☐ Who are deaf or hard-of hearing
   - ☐ Who are blind or visually impaired
   - ☐ With co-occurring disorders
   - ☐ Who are transgender
   - ☐ Other specialties: _____

9. *Practice location address office hours:
   - ☐ Monday: _____ a.m. to _____ p.m. ☐ Closed ☐ Open 24 hours
   - ☐ Tuesday: _____ a.m. to _____ p.m. ☐ Closed ☐ Open 24 hours
   - ☐ Wednesday: _____ a.m. to _____ p.m. ☐ Closed ☐ Open 24 hours
   - ☐ Thursday: _____ a.m. to _____ p.m. ☐Closed ☐ Open 24 hours
   - ☐ Friday: _____ a.m. to _____ p.m. ☐ Closed ☐ Open 24 hours
   - ☐ Saturday: _____ a.m. to _____ p.m. ☐ Closed ☐ Open 24 hours
   - ☐ Sunday: _____ a.m. to _____ p.m. ☐ Closed ☐ Open 24 hours

10. Is this location a Federally Qualified Health Center? ☐ Yes ☐ No
11. Is this location handicap accessible? ☐ Yes ☐ No

    If Yes, select the types of accessibility:
    - ☐ Exam Room (E)
    - ☐ Exam Table/Scale/Chair (T)
    - ☐ Exterior Building (EB)
    - ☐ Gurneys & Stretchers (G)
    - ☐ Interior Building (IB)
    - ☐ Parking (P)
    - ☐ Portable Lifts (PL)
    - ☐ Restroom (R)
    - ☐ Radiologic Equipment (RE)
    - ☐ Signage & Documents (S)

12. List the languages associated with this practice location address next to the 'spoken/written by' options, including American Sign Language, if applicable.

Spoken by:

Care Provider: _____

Staff: _____

Interpreter (ITP): _____

Interpreter and Care Provider (ITP PHYS): _____

Interpreter and Staff (ITP STAFF): _____

All: _____

Written by:

Care Provider: _____

Staff: _____

Interpreter (ITP): _____

Interpreter and Care Provider (ITP PHYS): _____

Interpreter and Staff (ITP STAFF): _____

All: _____

Is a skilled medical interpreter line available if this practice location doesn't have a skilled medical interpreter? ☐ Yes: _____ ☐ No

13. *Patient age restrictions associated with this practice location (ages in numerals; 0-999):

_____

14. Patient gender restrictions associated with this practice location :

☐ Male Only ☐ Female Only ☐ No Restrictions ☐ Restrictions are Unknown

15. If the care provider is participating in a UnitedHealthcare Community Plan network at this location:

State: _____ Medicaid ID: _____

16. If the care provider is participating in a UnitedHealthcare Medicare or Medicare Advantage network at this location:

Medicare ID: _____

Section III - Add or Update Care Provider to Group/Organization

☐ **The following care providers have left our practice *(all questions are required)***

Additional care providers must be listed on a separate roster and include the following information.

Name: _____ NPI: _____

TIN: _____ Effective Date (MM/DD/YYYY): _____

The care provider is leaving the group/contract TIN for the following reason:

☐ Care Provider Retired ☐ Care Provider Deceased ☐ Care Provider Left Group

☐ Care Provider Not Affiliated with TIN/Contract ☐ Provider Left Service Area ☐ Voluntary

☐ Leave of Absence ☐ Incorrect Data ☐ Other (Personal, Sabbatical, etc.)

For PCPs no longer associated with a TIN, UnitedHealthcare will reassign members to the listed care provider when available: _____

If we aren't able to assign to your selected care provider, UnitedHealthcare will identify an acceptable replacement.

Name: _____ NPI: _____

TIN: _____ Effective Date (MM/DD/YYYY): _____

The care provider is leaving the group/contract TIN for the following reason:

☐ Care Provider Retired ☐ Care Provider Deceased ☐ Care Provider Left Group

☐ Care Provider Not Affiliated with TIN/Contract ☐ Provider Left Service Area ☐ Voluntary

☐ Leave of Absence ☐ Incorrect Data ☐ Other (Personal, Sabbatical, etc.)

For PCPs no longer associated with a TIN, UnitedHealthcare will reassign members to the listed care provider when available: _____

If we aren't able to assign to your selected care provider, UnitedHealthcare will identify an acceptable replacement.

☐ **The following care providers have joined our practice *(all questions are required)***

Refer to Section IV for NPI definitions; Additional care providers must be listed on a separate roster and include the following information.

Care Provider Information

1. Care provider name:

   Last: _____ First: _____ MI: _____ Suffix _____

2. Joined group/organization effective (MM/DD/YYYY): _____

3. Date of birth (MM/DD/YYYY): _____

4. Gender: ☐ Male ☐ Female ☐ Unknown

5. Does the care provider have a Medicare identification number? ☐ Yes: _____ ☐ No

6. Does the care provider have a Medicaid identification number? ☐ Yes: _____ ☐ No
7. Is the care provider a primary care provider (PCP) or specialist? ☐ PCP ☐ Specialist
8. Is the care provider hospital-based operating solely in a hospital? ☐ Yes ☐ No
9. Is the care provider a hospitalist? ☐ Yes ☐ No
10. Does the care provider have hospital affiliations? ☐ Yes ☐ No

If Yes, list the hospital names next to the type of admitting privilege and hospital affiliation type.

- Active (AC): _____
- Active Admitting (ACT): _____
- Active Non-Admitting (NAC): _____
- Adjunction Staff (ADJ): _____
- Admitting (ADM): _____
- Affiliate (AFF): _____
- Assistant Adjunction (ATA): _____
- Assistant Attending (ACA): _____
- Associate (ASC): _____
- Attending (ATT): _____
- Clinical Privileges (CLP): _____
- Consulting (CON): _____
- Consulting Admitting (CN): _____
- Consulting Non-Admitting (NCN): _____
- Courtesy (COU): _____
- Courtesy Admitting (CT): _____
- Courtesy Non-Admitting (NCT): _____
- Deferred (DAP): _____
- Honorary (HON): _____
- Non-Admitting (NAN): _____
- Provisional Non-Admitting: (NPR): _____
- Unknown (UNK): _____

11. Remove the following hospital affiliations (hospital names): _____

_____

12. Is the care provider accepting UnitedHealthcare members as new patients? ☐ Yes ☐ No

☐ Care provider isn't accepting UnitedHealthcare members as new or existing patients.

13. Does the care provider accept new Medicaid patients? ☐ Yes ☐ No

☐ Care provider is not accepting new or existing Medicaid patients.

14. Does the care provider accept new Medicare patients? ☐ Yes ☐ No

☐ Care provider is not accepting new or existing Medicare patients.

15. Care provider's email address: _____ ☐ Not applicable

a. Is this email address for an individual care provider or the email address for an office location?

☐ Care Provider ☐ Location

b. List this email address in the care provider directory? ☐ Yes ☐ No

16. Care provider's website: _____ ☐ Not applicable

a. Is this an individual care provider's website or the website for an office location?

☐ Care Provider ☐ Location

b. List this website in the care provider directory? ☐ Yes ☐ No

17. Is the practitioner an Indian Health Service provider? ☐ Yes ☐ No

18. Does the care provider have telehealth service capability? ☐ Yes ☐ No

19. **National Provider Identifier (NPI) Number**

Refer to Section IV for details about NPI number requirements.

Is the care provider an atypical provider?

☐ Yes. NPI number is <u>not</u> required.

☐ No. *Complete the following NPI number information:

NPI Number: _____

NPI Number Taxonomy Code: _____

NPI Number Issue Date (MM/DD/YYYY): _____

Basis for NPI Number: _____

NPI Number Level of Information: _____

20. Care provider's primary specialty: _____

a. Is the care provider board-certified for this specialty? ☐ Yes ☐ No

21. Care provider's secondary/sub-specialty: _____ ☐ Not available

22. Care provider's expertise (when applicable) with individuals:

☐ With physical disabilities

☐ With chronic illness

☐ With HIV/AIDS

☐ With serious mental illness

☐ Who are homeless

☐ Who are deaf or hard-of hearing

☐ Who are blind or visually impaired

☐ With co-occurring disorders

☐ Who are transgender

☐ Other specialties: _____

23. Care provider's primary degree: _____ Secondary degree: _____

24. Care provider's board certifications: _____

25. Care provider's state licenses (please add dates as MM/DD/YYYY): _____

State: ____ License: _____ Effective Date: _____ Expiration Date: _____

State: ____ License: _____ Effective Date: _____ Expiration Date: _____

26. For mid-level care providers, list the supervising physician's information.

Name: _____ Specialty: _____

Mid-level care providers have a medical degree, but are not physicians. A mid-level provider can diagnose and treat patients under the supervision of a licensed physician or independently as allowed by state law and licensure.

27. Does the care provider have a Drug Enforcement Administration (DEA) registration number?

☐ Yes: _____ Expiration Date (MM/DD/YYYY): _____ ☐ No

28. Care provider cultural competency training dates (MM/DD/YYYY)

a. Communication Skills – Interpreter Services (CIS)

Effective Date: _____ Expiration Date: _____

b. Communication Skills – Language Availability (CLA)

Effective Date: _____ Expiration Date: _____

c. Communication Skills – Soft Skills (CSS)

Effective Date: _____ Expiration Date: _____

d. Financially Challenged Patients (FCP)

Effective Date: _____ Expiration Date: _____

e. Homeless (HL)

Effective Date: _____ Expiration Date: _____

f. LGBT Communities (LGB)

Effective Date: _____ Expiration Date: _____

g. People with Disabilities (PWD)

Effective Date: _____ Expiration Date: _____

h. Refugee or Immigrant Patients (RIP)

Effective Date: _____ Expiration Date: _____

i. Senior Care (SC)

Effective Date: _____ Expiration Date: _____

j. Unspecified (UNS)

Effective Date: _____ Expiration Date: _____

29. Is the care provider an Essential Community Provider (ECP)? An ECP serves mostly low-income, medically underserved individuals. ☐ Yes ☐ No

Care Provider Addresses

30. Care provider's billing address:

Street: _____ Suite/Other: _____

City: _____ State: _____ County: _____ ZIP+4: _____

Billing Phone: _____ Extension: _____ Practice Fax: _____

For billing correspondence purposes: ☐ Primary ☐ Secondary ☐ None

31. Care provider's practice location address:

Street: _____ Suite/Other: _____

City: _____ State: _____ County: _____ ZIP+4: _____

Practice Phone: _____ Extension: _____ Practice Fax: _____

For this practice location address, all of the following information is required.

a. This is the primary practice location address ☐ Yes ☐ No

b. The practice location address, for correspondence purposes is ☐ Primary ☐ Secondary ☐ None

32. Publish this location address in the UnitedHealthcare care provider directory as:

a. A UnitedHealthcare Community Plan participating care provider ☐ Yes ☐ No ☐ N/A

b. A UnitedHealthcare Medicare Advantage contracted care provider ☐ Yes ☐ No ☐ N/A

c. A UnitedHealthcare commercial participating care provider ☐ Yes ☐ No ☐ N/A

Only care providers who regularly practice at the specified location may be listed in the directory.

If you choose not to display the address in our directory, one of the following reasons must apply:

☐ Care provider is not active due to taking an extended leave of absence.

☐ Care provider is in the process of being removed from the UnitedHealthcare network.

☐ Care provider is under investigation for fraud, licensure or quality issues.

☐ Decline to publish care provider information because of one or more California-specific exemptions. Please attach a signed statement.

☐ The care provider is currently enrolled in the state's **Safe at Home program**.

☐ The care provider fears for their safety or their family's safety because of their affiliation with a health care service facility or because they provide health care services.

☐ This location, facility or any of its care providers, employees, volunteers or patients is or was the target of threats or acts of violence within the past year.

33. **National Provider Identifier (NPI) Number:**

Refer to Section IV for details about NPI number requirements.

a. NPI number associated with the practice location address (not required for atypical providers):

_____

☐ Not applicable

b. NPI number issue date (MM/DD/YYYY): _____

c. NPI number taxonomy code: _____

d. Primary specialty associated with this practice location address: _____

e. Additional specialty associated with this practice location address: _____

f. Additional specialty effective date (MM/DD/YYYY): _____

34. This location's expertise (when applicable) with individuals:

- ☐ With physical disabilities
- ☐ With chronic illness
- ☐ With HIV/AIDS
- ☐ With serious mental illness
- ☐ Who are homeless
- ☐ Who are deaf or hard-of hearing
- ☐ Who are blind or visually impaired
- ☐ With co-occurring disorders
- ☐ Who are transgender
- ☐ Other specialties: _____

35. Practice location address office hours:

- ☐ Monday: _____ a.m. to _____ p.m. ☐ Closed ☐ Open 24 hours
- ☐ Tuesday: _____ a.m. to _____ p.m. ☐ Closed ☐ Open 24 hours
- ☐ Wednesday: _____ a.m. to _____ p.m. ☐ Closed ☐ Open 24 hours
- ☐ Thursday: _____ a.m. to _____ p.m. ☐Closed ☐ Open 24 hours
- ☐ Friday: _____ a.m. to _____ p.m. ☐ Closed ☐ Open 24 hours
- ☐ Saturday: _____ a.m. to _____ p.m. ☐ Closed ☐ Open 24 hours
- ☐ Sunday: _____ a.m. to _____ p.m. ☐ Closed ☐ Open 24 hours

36. Is this location a Federally Qualified Health Center ☐ Yes ☐ No

37. Is this location handicap accessible? ☐ Yes ☐ No

If Yes, select the types of accessibility:

- ☐ Exam Room (E)
- ☐ Exam Table/Scale/Chair (T)
- ☐ Exterior Building (EB)
- ☐ Gurneys & Stretchers (G)
- ☐ Interior Building (IB)
- ☐ Parking (P)
- ☐ Portable Lifts (PL)
- ☐ Restroom (R)
- ☐ Radiologic Equipment (RE)
- ☐ Signage & Documents (S)

38. List the languages associated with this practice location address next to the 'spoken/written by' options, including American Sign Language, if applicable.

Spoken by:

i. Care Provider: _____

ii. Staff: _____

iii. Interpreter (ITP): _____

iv. Interpreter and Care Provider (ITP PHYS): _____

v. Interpreter and Staff (ITP STAFF): _____

vi. All: _____

Written by:

i. Care Provider: _____

ii. Staff: _____

iii. Interpreter (ITP): _____

iv. Interpreter and Care Provider (ITP PHYS): _____

v. Interpreter and Staff (ITP STAFF): _____

vi. All: _____

Is a skilled medical interpreter line available if this practice location doesn't have a skilled medical interpreter? ☐ Yes: (_____) _____ ☐ No

39. Patient age restrictions associated with this practice location (ages in numerals; 0-999):

_____

40. Patient gender restrictions associated with this practice location :

☐ Male Only ☐ Female Only ☐ No Restrictions ☐ Restrictions are Unknown

41. If the care provider is participating in a UnitedHealthcare Community Plan network at this location:

State: _____ Medicaid ID: _____

42. If the care provider is participating in a UnitedHealthcare Medicare or Medicare Advantage network at this location:

Medicare ID: _____

Section IV - National Provider Identifier (NPI) Number Definitions and Requirements

The National Provider Identifier (NPI) number is a federal requirement; however, **atypical** providers are not required to have an NPI number. **Atypical** providers are individuals and organizations that furnish 'atypical' or non-traditional services that are indirectly health care related, such as taxi service, home and vehicle modifications, habilitation and respite services.

Basis for NPI Number	NPI Number Level of Information
C – Entity whose name is on the W-9	Tax ID number and name filed on the W-9: Legal owner of TIN - does not bill for medical services. Indicate if it's a Social Security number (SSN) or TIN.
D – Department	Department name: If the organization or sub-part was enumerated on the basis of a particular department, provide the Department Name that the NPI was based on, and designate this with a "D" in the "Basis for NPI" field. Insert the Department Name in the "Level Information" field.
L – License	License number and state or state code: If the organization or sub-part was enumerated by License, provide the state or state code and License Number that the NPI was based on, and designate this with an "L" in the "Basis for NPI" field. Insert the License Number and state or state code in the "Level Information" field.
P – Place of service address	Place of service address (street, city, state, ZIP+4) If the organization was enumerated by place of service address, provide the street address that the NPI was based on and designate this with a "P" in the "Basis for NPI" field. Insert the Place of Service address in the "Level Information" field. **List NPI number for each Group/Organization Place of Service**
T – Tax ID number and provider name	Tax ID number and Provider Name where care provider is not the same on the W-9, but bills with this TIN. Indicate whether the Tax ID number is a SSN or TIN.
X – Taxonomy	NUCC Taxonomy Code: If the organization or sub-part was enumerated by a NUCC Taxonomy code, provide the Taxonomy Code that the NPI was based on and designate this with an "X" in the "Basis for NPI" field. Place the NUCC Taxonomy Code in the "Level Information" field.
O – Other	Any other basis for the NPI number: Provide any other basis for NPI in the "Basis for NPI Number" field and designate as "O", with a description of the basis for that NPI in the "Level Information" field.
M – Name	Insert the name of the care provider (physician or allied health professional) in the "Level Information" field.

Section V – Sign and Submit

Submit completed forms, required information and any additional rosters to hpdemo@uhc.com.

*Person completing this form: _____ *Date: _____

Title: _____

*Telephone: (_____) _____ *Office Contact: _____

Insurance coverage provided by or through UnitedHealthcare Insurance Company, All Savers Insurance Company, Oxford Health Insurance, Inc. or their affiliates. Health Plan coverage provided by UnitedHealthcare of Arizona, Inc., UHC of California DBA UnitedHealthcare of California, UnitedHealthcare Benefits Plan of California, UnitedHealthcare of Colorado, Inc., UnitedHealthcare of Oklahoma, Inc., UnitedHealthcare of Oregon, Inc., UnitedHealthcare of Texas, LLC, UnitedHealthcare Benefits of Texas, Inc., UnitedHealthcare of Utah, Inc. and UnitedHealthcare of Washington, Inc., Oxford Health Plans (NJ), Inc. and Oxford Health Plans (CT), Inc. or other affiliates. Administrative services provided by United HealthCare Services, Inc., OptumRx, OptumHealth Care Solutions, LLC, Oxford Health Plans LLC or their affiliates. Behavioral health products are provided by U.S. Behavioral Health Plan, California (USBHPC), United Behavioral Health (UBH) or its affiliates.

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