

# Provider data verification for New Jersey

Response required

In regard to: **Provider ID:** \_\_\_\_\_

UnitedHealthcare Community Plan of New Jersey is verifying information for the provider listed on this form. Please provide any missing information. Please cross out any incorrect information and write in the corrected information. **If the provider no longer works at this facility, please indicate and return as soon as possible.** Once you have completed this review, please email to [nj\\_provider\\_mgmt@uhc.com](mailto:nj_provider_mgmt@uhc.com) within 5 days of receipt.

## Please verify the following

Physician no longer at this location

Please provide a forwarding address:

Physician does not participate with UnitedHealthcare Community Plan (AmeriChoice)

Physician no longer with the practice

## Provider information

First name:

Last name:

Degree:

Practice name:

Street address:

City:

State:

ZIP code:

County:

Correct:    Yes    No

## Billing information

Full name:

Vendor street address:

City:

State:

ZIP code:

Correct:    Yes    No

Phone number:

Correct:    Yes    No

Fax number:

Correct:    Yes    No

Will you provide care including referrals for a minor seeking family planning services?    Yes    No

**Do providers in this office serve members with special needs:**

Aged/elderly? Yes No | Neurodevelopment (Neurodiversity) disabilities Yes No

HIV/AIDS? Yes No

**For OB/GYNs only:** Does the office specialize in high-risk obstetrical care? Yes No

Tax ID number: Correct: Yes No

If the tax ID is **not correct**, please fax **corrected W-9** to 866-943-0517

National Provider Identification number: Correct: Yes No

**Hospital privileges:**

Hospital privilege 1:

Hospital privilege 2:

Hospital privilege 3:

**Additional hospital privileges:**

Primary languages spoken other than English:

Language code 1: Language code 2: Language code 3:

Do you perform lead screenings in your office? Yes No

If yes, are you using the filter paper method (MedTox)? Yes No

Specialty: Correct: Yes No

Is your office accessible? Yes No | Is the practitioner accepting new patients? Yes No

Office hours: Correct: Yes No

**Surgeon section**

Do you still perform surgery? Yes No

If yes, please indicate the specialization(s) - back, knees, etc.:

If no, do you limit patient care to office procedures? Yes No

Do you actively use certified electronic health record technology (CEHRT) in your practice? Yes No

Have you successfully attested to the CMS Promoting Interoperability Program (formerly Medicaid or Medicare EHR Incentive Program), as specified by the HITECH Act in Article 42 U.S.C.?  
Yes No

## Surgeon section (cont.)

Are you actively engaged with or connected to HIE, a TDSO, or to the NJHIN?	Yes	No
Do you deliver or can you deliver the indicated specialty to members via appropriate telemedicine methods?	Yes	No
Do you provide member in-resident visits (not via telemedicine)?	Yes	No
Are you a CDC-recognized provider of diabetes prevention program?	Yes	No
Do you provide vaccines for children?	Yes	No

Please provide your DOH PIN and location:

DOH PIN:

Location:

Signature is required to allow us to make changes indicated in this form to your current provider record:

Signature:

Date:

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