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** 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) ☐ Yes ☐ No in your practice?
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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United Healthcare® Community Plan