Join our network request submission – Ancillary providers and centers

National ancillary medical benefit health care facility questionnaire

To join our network as a national ancillary medical benefit health care facility, complete this form and visit **uhcprovider.com/contactus** to connect with us through chat for submission instructions.

Go to **Ancillary providers** for more details on joining our network, including required documentation and submission instructions.

Provider type (select all that apply to your entity*):			
☐ **Ambulatory infusion suite**	☐ **Home infusion**	☐ **Specialty pharmacy**	☐ **Hemophilia treatment center**
Eligibility criteria			
Joint Commission on Accreditation of Healthcare Organizations (JCAHO), Utilization Review Accreditation Commission (URAC), Community Health Accreditation Program (CHAP) or Accreditation Commission for Health Care (ACHC) or The Compliance Team (TCT)	JCAHO, URAC, CHAP, TCT or ACHC accreditation	URAC accreditation	Federally funded covered entity in the 340B Drug Pricing Program
National Provider Identifier (NPI) number taxonomy code: 261QI0500X	Home-based short-term acute drugs and long-term chronic medications administered by a nurse	National geographic service area**	NPI taxonomy code: 3336S0011X

* Excludes physician-based infusion clinics and hospital-based infusion clinics.
** Hospital-owned specialty pharmacies must be pre-approved for medical benefit contracting. Hospital-owned specialty pharmacies will be contracted to dispense medications only within the physical geographic coverage.

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Provider type (select all that apply to your entity*):			
☐ **Ambulatory infusion suite**	☐ **Home infusion**	☐ **Specialty pharmacy**	☐ **Hemophilia treatment center**
Eligibility criteria			
	NPI Taxonomy code: 3336H0001X	Dispensing of medications to physician office or outpatient rehabilitation hospital clinic	
		NPI taxonomy code: 3336S001X	
Place of service = 12 (billed with -SS modifier)	**Place of service = 12**	**Place of service = 11**	**Place of service = 12**

Tax ID number (TIN)			
TIN	**National Provider Identifier (NPI) number**	**Associated legal name**	**Legal DBAs affiliated with provider**
Ex: 987654321	*1234567891*	*Legal Name, Inc.*	*Doing business as [name]*

If additional space is needed, please submit a separate attachment

Provider contact and billing information	
Contact name:	Title:
Contact email:	Phone number:
Mailing address:	
Practice website URL:	
Billing address:	

* Excludes physician-based infusion clinics and hospital-based infusion clinics.
** Hospital-owned specialty pharmacies must be pre-approved for medical benefit contracting. Hospital-owned specialty pharmacies will be contracted to dispense medications only within the physical geographic coverage.

Service information

A sample claim form for each provider type you are applying for (e.g., ambulatory infusion suite, home infusion, specialty pharmacy and/or hemophilia treatment center) is required to evaluate your application.

Are you currently contracted with any UnitedHealthcare plans? ☐ Yes ☐ No

If yes, which? ☐ UnitedHealthcare Community Plan ☐ UnitedHealthcare commercial plans ☐ UnitedHealthcare® Medicare Advantage

We require Medicare enrollment to include you in UnitedHealthcare Community Plan. Please provide dated Medicare participation documentation.

Please provide the applicable Medicaid IDs by state in which you do business.

Please provide all organization and operational licenses your legal entity holds by state in which you do business.

A copy of the accreditation certificate that your entity holds must be included in your submission. Acceptable accreditation institutions are outlined on page 1.

If you're requesting a new contract, please indicate which products and states you are seeking a contract for: ☐ Medicare & Retirement ☐ Commercial plan(s) ☐ Community Plan(s)

Update the names of these plans as indicated above

Please itemize specific plans by state:

Please describe the classes of trade to which you acquire medications with manufacturers or wholesalers:

Please provide an itemized list of chronic or specialty pharmacy medical benefit medications that you wish to administer for UnitedHealthcare members with corresponding HCPCS/CPT® codes and brand names:

Service categories (applicable only to home infusion, specialty pharmacy and ambulatory infusion suite)				
Acute Home infusion categories	**Chronic** Home infusion/specialty pharmacy/ambulatory infusion suite categories			
☐ Anti-coagulation	☐ Alcohol dependence	☐ Diagnostic	☐ Interstitial cystitis	☐ Psoriasis
☐ Anti-emetic IV therapy	☐ Anemia	☐ Endocrine	☐ Macular degeneration	☐ Pulmonary hypertension
☐ Anti-infective therapy	☐ Anticoagulants	☐ Enzyme deficiency	☐ Monoclonal antibody miscellaneous	☐ Rheumatoid arthritis
☐ Catheter insertion and maintenance supplies	☐ Antiemetic	☐ Gaucher disease	☐ Multiple sclerosis	☐ RSV prevention
☐ Chemotherapy infusion	☐ Antipsychotic	☐ Hematologic	☐ Neutropenia	☐ Severe spasticity
☐ Enteral nutrition	☐ Asthma	☐ Hemophilia	☐ Oncology – injectable	☐ Thrombolytic agents prevention
☐ Hydration	☐ Biologics	☐ Hepatitis B	☐ Oncology – oral	☐ Transplant
☐ Pain management	☐ Blood-modifying agent	☐ Hepatitis C	☐ Oncology - multiple sclerosis	☐ Uveitis
☐ Total parenteral nutrition	☐ Cardiovascular/ heart failure	☐ HIV/Aids	☐ Ophthalmic/ optic	These are the only drug categories available for medical benefit contracting based on coverage. Category inclusion contingent on provider type.
☐ Aerosolized drug therapy	☐ Cervical dystonia	☐ Inflammatory	☐ Osteoarthritis	
☐ Chelation therapy	☐ CNS agents	☐ Immune globulin	☐ Osteoporosis	

Service categories (applicable only to home infusion, specialty pharmacy and ambulatory infusion suite) (cont.)

Acute Home infusion categories	**Chronic** Home infusion/specialty pharmacy/ambulatory infusion suite categories			
☐ Inotropic	☐ Cystic fibrosis	☐ Immune modulator	☐ Pain management	These are the only drug categories available for medical benefit contracting based on coverage. Category inclusion contingent on provider type.
	☐ Dermatologic	☐ Infertility	☐ Parkinson's disease	

Attestation

☐ I attest that information entered above is accurate and valid and that I have attestation authority. This attestation acknowledges willingness and capability of submitting claims according to the UnitedHealthcare **National Drug Codes** claim submission and inquiry procedures for NDC billing units/ppoONE billing policy.

Signature of person who completed this form:	**Printed name:**
Title:	**Date of submission:**

Required documents

Your application will not be evaluated without the following required documents:

- Proof of accreditation
- State license
- Medicare enrollment status
- Proof of enrollment in individual state
- Medicaid plan(s), if applicable
- W-9

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