UnitedHealthcare Community Plan

Network Participation Request Form

Instructions/Checklist

Before you begin…

1) **Are you already part of the United Healthcare Community Plan (UHCCP) of Tennessee network?**
   If you are unsure, check the provider directory found at uhccommunityplan.com > Tennessee or, call 1-800-690-1606.
2) **Are you part of a group practice that is contracted with us?**
   If so, please consult with your group administrator regarding the process for joining the UHCCP network prior to submitting any documents.

If you are not currently part of the UHCCP network and would like to be considered for participation, please fully complete and submit the following documents. Incomplete documents may delay our response to your request.

Network Participation Request Form - Return pages 2, 3, 4, 5 & 8

- ☐ Page 2
  - Fully complete Sections A and B.
- ☐ Page 3-4
  - Check at least one area of expertise/population treated. Do not leave blank.
- ☐ Page 5
  - Provide requested supporting documents, if applicable.
  - If no attested specialties are applicable, check the "No Specialties" box.
  - Check Acknowledgment box and sign Attestation page.
- ☐ Page 8
  - *Substitute Form W-9* (or IRS *Form W-9*) must be signed and dated by the clinician or the controller of the tax identification number. Each tax identification number requires a separate *Substitute Form W-9* or IRS *Form W-9*.

Individual Contract Documents (not required for clinicians who are part of a contracted group practice)

- ☐
  - Retain a full copy of the Agreement and any Attachments, Amendments, Disclosure Forms and/or state required forms for your records. (Note – The *Network Manual* is, by extension, part of the Agreement. The *Manual* can be review at uhccommunityplan.com > For Health Care Professionals > Select Tennessee > Provider Manuals.
  - Complete and sign the Agreement signature page.
  - Complete and sign any Attachment/Amendment &/or Disclosure Forms, if signature is required.

How to Submit Your Documents

Return completed documents to the fax number or email address provided by your Network Manager or Provider Advocate.

UHCCP Network Participation Request Process
Frequently Asked Questions

How long is the credentialing process?

Credentialing is completed in accordance with applicable laws and averages 30 days. If you have not heard back from us after 30 days, you may inquire about the status of your credentialing by contacting Network Management.

What UHCCP documents should be completed or provided & faxed to Network Management to request network consideration?

- Network Participation Request Form, Clinical Expertise Checklist. Specialty Attestation and Substitute Form W-9 (complete and return pages 2, 3, 4, 5 and 8)
- State-specific Amendments or Attachments (if applicable)

May I begin to see UHCCP members while I am going through the credentialing process? If yes, what is the member's financial responsibility?

You are not considered an "in-network" clinician until your credentialing is complete. In some cases, members may choose to access out- of-network benefits; members will generally incur greater out-of-pocket expenses by making this choice.

Why does UHCCP use CAQH for credentialing and recredentialing?

The CAQH web-based credentialing tool streamlines the credentialing process by enabling you to complete your credentialing application online and is available to you at no cost 24 hours a day, 365 days a year. You may save your application and return to it at any time.

Do I need to have a CAQH number before I can apply to the UHCCP network?

No. If you do not already have a CAQH number, UHCCP will provide you with one once the determination is made to move forward with the recruitment process.

Does CAQH notify UHCCP when my application is completed or when I make demographic or other updates?

No. It is your responsibility to notify UHCCP when your application is completed or when you make any updates to demographic or other information included on CAQH.

I have completed my application on CAQH; does that mean I am on the UHCCP panel?

No. CAQH stores the online application, but UHCCP must still verify your credentials and evaluate your application through our Credentialing Committee prior to approval of your participation on the panel.

If I am added to the panel, how will UHCCP notify me of my contract start date?

Once approved, you will receive an acceptance letter stating your effective date with UHCCP.

Does my credentialing/re-credentialing correspondence address have to be the same as my practice location?

No. The credentialing/re-credentialing correspondence address does not have to be the same as your practice location. It cannot, however, be a P.O. Box; it must be a physical address. There is one re-credentialing address per clinician, not per location.

Am I required to have a secure fax number or secure email?

While it is recommended that you have both a secure fax number and a secure email, you are required to have only one of these forms of secure electronic communication for transmittal of confidential information. The definition of a secure fax is having a business dedicated fax number in a secure location (not accessible or visible to your clients, visitors or family while you are in session or away from the office). The definition of secure email is that the email account be a business dedicated, password protected account accessible only to you and appropriate office staff.

Am I required to have online capabilities?

No. UHCCP allows claims to be submitted electronically either through our UHCCP portal (available at no cost to you) or through an Electronic Data Interchange (EDI) vendor. Additionally, other critical information regarding your contract will be posted on line.

Are there other requirements?

In applying to the UHCCP panel you are agreeing to participate in all Care Management and Quality Improvement Programs sponsored by UHCCP including, but not limited to the submission of patient Wellness Assessment forms as part of our outcomes evaluation program, ALERT®.

UnitedHealthcare Community Plan

Network Participation Request Form

IMPORTANT NOTE: *Please complete fully. Incomplete forms will delay the response to this inquiry. For clinicians in "any willing provider" states, please note that network inclusion is based solely on meeting our minimum credentialing standards as outlined in the Credentialing Plan. Information submitted on this form must match your CAQH application.*

SECTION A - CLINICIAN INFORMATION:

Clinician's Name _____ Gender ☐ Female ☐ Male

Credentialing/Re-credentialing contact information

(Disclaimer: we can only hold 1 credentialing contact name/address per clinician & a correspondence address cannot be a P.O. Box)

Credentialing Contact Name _____ Phone _____

Address _____ City _____ State _____ Zip _____

Fax # _____ Credentialing Email _____

Council for Affordable Quality Healthcare (CAQH) Participant? ☐ Yes ☐ No If yes, list CAQH # * _____

If you do not have a CAQH number, UHCCP will provide the number, once the determination is made to recruit.

* UHCCP accepts credentialing application submission through CAQH or by other state approved applications, as applicable. For more information regarding CAQH you may visit their website at www.CAQH.org.

(1) Professional License Type _____ & License # _____ Original Independent License Issue Date _____

(2) Professional License Type _____ & License # _____ Original Independent License Issue Date _____

IMPORTANT NOTE: Please list any independent license previously held in another state (if applicable).

SS# _____ DOB _____ Clinician's e-mail _____

Individual NPI (Type I) _____ Individual. Taxonomy Code _____

Group NPI (Type II) _____ Group Taxonomy Code _____

Individual Medicaid # _____ Individual Medicare # _____

Board Certified Physician ☐ Yes If yes, list board/cert date _____

☐ No If no, psychiatric fellowship/residency training completion date _____

Hospital Affiliation(s) _____ Attending ☐ Yes ☐ No

SECTION B – PRACTICE INFORMATION: - addresses & TIN(s) below must match CAQH application

Primary Practice

Practice Name _____ TIN # _____

Website _____ Public Email _____
(optional – for display in provider directory)

Physical Practice Address _____

City _____ State _____ Zip _____ County _____

Phone # _____ Secure fax# (required) _____

Additional Practice

Practice Name _____ TIN # ** _____

Physical Practice Address _____

City _____ State _____ Zip _____ County _____

Phone # _____ Secure fax# _____

***If you have more than one additional TIN/group affiliation, please complete information contained in Section B on an additional piece of paper & include corresponding Substitute Form W-9 or IRS W-9 for the additional TIN(s).*

Mailing Address _____

City _____ State _____ Zip _____ County _____

LIST ALL LANGUAGES (including sign language) in which you are able to conduct treatment:

Optional –Clinician's own Ethnicity (data utilized to meet member referral requests):

☐ African American ☐ Alaska Native ☐ Native-American Indian ☐ Asian

☐ Caucasian ☐ Hispanic ☐ Native Hawaiian or Pacific Islander ☐ Other

UHCCP

Clinical Expertise Checklist

Clinician Name: _____ **CAQH #** _____

Clinicians in the credentialing or recredentialing process have the following rights:

- to review information submitted to support his/her (re)credentialing application
- to correct erroneous information obtained by UHCCP to evaluate his/her (re)credentialing application (not including references, recommendations and other peer-review protected information)
- to submit any corrections, in writing, within ten (10) days
- to obtain, upon request, information regarding the status of their application

Areas of Clinical Expertise

Please check all areas you have clinical training and experience *AND* are currently willing to treat in your practice.

- ☐ Abuse (Physical, Sexual, etc.)
- ☐ Adoption Issues
- ☐ Anger Management
- ☐ Anxiety
- ☐ Assessment and Referral – Substance Abuse
- ☐ Attention Deficit Disorders (ADHD)
- ☐ Autism Spectrum Disorders
- ☐ Bariatric/Gastric Bypass Evaluation
- ☐ Behavior Modification
- ☐ Biofeedback
- ☐ Bipolar Disorder
- ☐ Bisexual Issues
- ☐ Blindness or Visual Impairment
- ☐ Case Management
- ☐ Certified Pastoral Counselor
- ☐ Child Welfare
- ☐ Christian Counseling
- ☐ Co-Occurring Disorders Treatment (Dual Diagnosis)
- ☐ Cognitive Behavioral Therapy
- ☐ Community Integration Counseling
- ☐ Compulsive Gambling
- ☐ Depression
- ☐ Developmental Disabilities
- ☐ Dialectical Behavioral Therapy
- ☐ Disability Evaluation/Management (submit "Memorandum of Understanding", ~~located on providerexpress.com~~
- ☐ Dissociative Disorders
- ☐ Domestic Violence
- ☐ Electroconvulsive Therapy (ECT)
- ☐ Evaluation and Assessment – Mental Health
- ☐ Eye Movement Desensitization & Reprocessing (EMDR)
- ☐ Feeding and Eating Disorders
- ☐ Fetal Alcohol Syndrome
- ☐ Forensic
- ☐ Gay/Lesbian Identified Clinician
- ☐ Gay/Lesbian Issues
- ☐ Grief/Bereavement
- ☐ Health and Behavior Assessment and Intervention Services
- ☐ Hearing Impaired Populations
- ☐ HIV/AIDS/ARC
- ☐ Home Care/Home Visits
- ☐ Hypnosis
- ☐ Independent/Qualified Medical Examiner
- ☐ Infertility
- ☐ Intellectual and Developmental Disability
- ☐ Intensive Individual Support
- ☐ Learning Disabilities
- ☐ Long Term Care
- ☐ Long-Acting Injectable (LAI) Administrator
- ☐ Medical Illness/Disease Management
- ☐ Medicaid Opioid Treatment Program (OTP) – Physicians Only
- ☐ Medication Management
- ☐ Military/Veterans Treatment
- ☐ Mobile Mental Health Treatment
- ☐ Mood Disorder
- ☐ Multi-Systemic Therapy (MST)
- ☐ Naltrexone Injectable MAT

Areas of Clinical Expertise (cont)

- ☐ Nursing Home Visits
- ☐ Obsessive Compulsive Disorder
- ☐ Organic Disorders
- ☐ Pain Management
- ☐ Parent Support and Training
- ☐ Personality Disorders
- ☐ Phobia
- ☐ Physical Disabilities
- ☐ Police/Fire Fighters
- ☐ Positive Behavioral Interventions & Supports
- ☐ Post-Partum Depression
- ☐ Post-Traumatic Stress Disorder (PTSD)
- ☐ Psych Testing
- ☐ Psychotic/Schizophrenic Disorders
- ☐ Rape Issues
- ☐ Regional Behavioral Health Authority (RHBA)
- ☐ School Based Services
- ☐ Serious Mental Illness
- ☐ Sex Offender Treatment
- ☐ Sexual Dysfunction
- ☐ Sleep-Wake Disorders
- ☐ Somatoform Disorders
- ☐ Targeted Case Management
- ☐ TBI Waiver – Case Management
- ☐ TBI Waiver – Community Integration Counseling
- ☐ TBI Waiver – Positive Behavior
- ☐ Transgender
- ☐ Trauma Therapy
- ☐ Traumatic Brain Injury
- ☐ Weapons Clearance
- ☐ Workers' Compensation

Population(s) Treated (check all that apply):

- ☐ Adult
- ☐ Child
- ☐ Adolescent
- ☐ Geriatric
- ☐ Couples/Marriage Therapy
- ☐ Family Therapy
- ☐ Group Therapy
- ☐ Inpatient

UHCCP Specialty Attestation

You must sign this document even if you are not requesting any of these specialty designations in your provider record. Additional training, experience, requirements, and/or outside agency approval is required for the following populations, professional certifications, and specialties. **Please review Specialty Requirements on pages 6-7**.

If you are not requesting a specialty designation, please check the "No Specialties" box at the bottom of the list to indicate you have read this form and acknowledge that you have not requested these specialties.

I have reviewed the UHCCP Specialty Requirements criteria that a Clinician must meet to be considered a specialist in the following treatment areas. After reviewing the criteria, I hereby attest that by placing a check next to a specialty or specialties, I meet UHCCP requirements for that treatment area.

Physician Specialties	Non-Physician Specialties
☐ Child/Adolescent (please specify all ages that you treat) ☐ Infant Mental Health *(0-3 years)* ☐ Preschool *(0-5 years)* ☐ Children *(6-12 years)* ☐ Adolescents *(13-18 years)* ☐ Geriatrics ☐ Buprenorphine – Medication Assisted Treatment (MAT) (**submit DEA registration with the DATA 2000 prescribing identification number**) ☐ Chemical Dependency / Substance Abuse / Substance Use Disorder (SUD) ☐ Medicaid Office-Based Opioid Treatment Program (OBOT) ☐ Neuropsychological Testing ☐ Substance Abuse Expert (**submit Nuclear Regulatory Commission qualification training certificate)** ☐ Transcranial Magnetic Stimulation (TMS)	☐ Child/Adolescent (please specify all ages that you treat) – *Psychologists only* ☐ Infant Mental Health *(0-3 years)* ☐ Preschool *(0-5 years)* ☐ Children *(6-12 years)* ☐ Adolescents *(13-18 years)* ☐ Certified Employee Assistance Professional **(submit CEAP certificate)** ☐ Chemical Dependency / Substance Abuse / Substance Use Disorder (SUD) ☐ Critical Incident Stress Debriefing **(submit CISD certificate)** ☐ Employee Assistance Professional ☐ Neuropsychological Testing – *Psychologists only* ☐ Nurses and Physician Assistants – Buprenorphine – Medication Assisted Treatment (MAT) (submit certification email from DEA) ☐ Nurses–Prescriptive Privileges **(submit ANCC certificate, Prescriptive Authority, DEA certificate and/or State Controlled Substance certificate, based upon state requirement)** ☐ Substance Abuse Expert (**submit Nuclear Regulatory Commission qualification training certificate)** ☐ Substance Abuse Professional **(submit Department of Transportation certificate)** ☐ Veterans Administration Mental Health Disability Examination – *Psychologists only*

☐ **No Specialties (must be checked if no other specialties are being designated)**

I understand that UHCCP may require documentation to verify that I meet the criteria outlined under Specialty Requirements pertaining to the specialty or specialties I have designated above. I will cooperate with an UHCCP documentation audit, if requested, to verify that I meet the required criteria.

I hereby attest that all of the information above is true and accurate to the best of my knowledge. I understand that any information provided pursuant to this attestation that is subsequently found to be untrue and/or incorrect could result in my termination from the UHCCP network.

Please note that standard credentialing criteria must be met before specialty designation can be considered. All clinicians must sign this form whether specialties are applicable or not. Failure to sign this form may cause a delay in the processing of your initial credentialing file.

☐ I acknowledge that I have read the Agreement, *Network Manual*, and, if applicable for my state, the State Regulatory Attachment and Medicaid Regulatory Attachment.

Printed Name of Applicant: _____

Signature of Applicant _____

Signature stamps are not accepted.

Important Note: Signature on the UHCCP Specialty Attestation page is required of all applicants

PHYSICIAN SPECIALTY REQUIREMENTS

CHILD/ADOLESCENT:
- Completion of an ACGME approved Child and Adolescent Fellowship *OR* recognized certification in Adolescent Psychiatry (This specialty includes Infants, Preschool, Children and Adolescents)

GERIATRICS:
- Completion of an ACGME approved Geriatric Fellowship *OR* recognized certification in Geriatric Psychiatry

BUPRENORPHINE – MEDICATION ASSISTED TREATMENT:
- DEA registration certificate with the DATA 2000 prescribing identification number

CHEMICAL DEPENDENCY / SUBSTANCE ABUSE / SUBSTANCE USE DISORDER:
- Completion of an ACGME Board certification in addiction psychiatry *OR* certification in addiction medicine *OR* certified by the American Society of Addiction Medicine (ASAM)/renamed American Board of Addiction Medicine (ABAM)

MEDICAID OFFICE-BASED OPIOID TREATMENT PROGRAM (OBOT):
- State certificate, if applicable in your state

NEUROPSYCHOLOGICAL TESTING:
- Recognized certification in Neurology through the American Board of Psychiatry and Neurology *OR*
- Accreditation in Behavioral Neurology and Neuropsychiatry through the American Neuropsychiatric Association

AND all of the following criteria:
- State medical licensure does not include provisions that prohibit neuropsychological testing service;
- Evidence of professional training and expertise in the specific tests and/or assessment measures for which authorization is requested;
- Physician and supervised psychometrician adhere to the prevailing national professional and ethical standards regarding test administration, scoring, and interpretation.

SUBSTANCE ABUSE EXPERT (SAE) – Nuclear Regulatory Commission (NRC):
- Certificate of NRC SAE qualification training (agencies providing such certification include, but are not limited to, ASAP, Inc, Program Services, and SAPAA)

TRANSCRANIAL MAGNETIC STIMULATION (TMS)
- Completed all training related to use of devices utilized in the Neurostar TMS Therapy System or Brainsway Deep TMS system

PSYCHOLOGISTS, NURSES & MASTER'S LEVEL CLINICIANS SPECIALTY REQUIREMENTS

CHILD/ADOLESCENT – Psychologists Only:
- Completion of an APA approved or other accepted training/certification program in Clinical Child Psychology (This specialty includes Infants, Preschool, Children and Adolescents)

CERTIFIED EMPLOYEE ASSISTANCE PROFESSIONAL (CEAP):
- Certificate from the Employee Assistance Certification Commission

CHEMICAL DEPENDENCY / SUBSTANCE ABUSE / SUBSTANCE USE DISORDER:
- Completion an APA or other accepted training in Addictionology

OR
- Certification in Addiction Counseling

AND one (1) or more of the following:
- Ten (10) hours of CEU in Substance Abuse in the last twenty-four (24) month period
- Evidence of twenty-five percent (25%) practice experience in substance abuse

CRITICAL INCIDENT STRESS DEBRIEFING:
- Certificate of CISD training from American Red Cross or Mitchell model
- Documentation of training and CEU units in the provision of CISD services

EMPLOYEE ASSISTANCE PROFESSIONAL (EAP):
- Minimum of two (2) years' experience in the delivery of EAP core technology as defined by EAPA, and
- Minimum of one (1) annual training (CEU credits or professional development hours) in any of the eight (8) EAP content areas

NEUROPSYCHOLOGICAL TESTING – Psychologists Only:
- Member of the American Board of Clinical Neuropsychology OR the American Board of Professional Neuropsychology

OR
- Completion of courses in Neuropsychology including: Neuroanatomy, Neuropsychological testing, Neuropathology, or Neuropharmacology
- Completion of an internship, fellowship, or practicum in Neuropsychological Assessment at an accredited institution

AND
- Two (2) years of supervised professional experience in Neuropsychological Assessment

NURSES & PHYSICIAN ASSISTANTS - BUPRENORPHINE – MEDICATION ASSISTED TREATMENT:
- Certification from DEA

PSYCHOLOGISTS, NURSES & MASTER'S LEVEL CLINICIANS SPECIALTY REQUIREMENTS (cont.)
NURSES REQUESTING PRESCRIPTIVE AUTHORITY MUST: ▪ Possess a currently valid license as a Registered Nurse in the state(s) in which you practice ▪ Be authorized for prescriptive authority in the state in which you practice ▪ Meet state specific mandates for the state in which you practice regarding DEA license and physician supervision ▪ Attest that you meet your state's collaborative or supervisory agreement requirements ▪ Specifically request prescriptive privileges on the UHCCP application above
SUBSTANCE ABUSE EXPERT (SAE) - Nuclear Regulatory Commission (NRC): To qualify as an SAE for the NRC, you must possess one of the following credentials: ▪ Licensed or certified social worker ▪ Licensed or certified psychologist ▪ Licensed or certified employee assistance professional ▪ Certified alcohol and drug abuse counselor - The NRC recognizes alcohol and drug abuse certification by the National Association of Alcoholism and Drug Abuse Counselors Certification Commission (NAADAC) or by the International Certification Reciprocity Consortium/Alcohol and Other Drug Abuse (ICRC/AODA). AND ▪ Certificate of NRC SAE qualification training (agencies providing such certification include, but are not limited to, ASAP, Inc., Program Services, and SAPAA)
SUBSTANCE ABUSE PROFESSIONAL (SAP): ▪ Certificate of training in federal Department of Transportation SAP functions and regulatory requirements (agencies providing such certification include, but not limited to, Blair and Burke, EAPA and NMDAC)
VETERANS ADMINISTRATION MENTAL HEALTH DISABILITY EXAMINATION – Psychologists Only: ▪ Graduate of an American Psychological Association accredited university (qualification counts even if accreditation occurred after date of graduation) ▪ Wheelchair accessible office ▪ PC user (Macintosh/Mac computers do not interface with the testing software used in the Disability Examination) ▪ Agree to participate in initial and annual training programs as required by LHI ▪ Agree to offer appointments within 10 to 14 days of the request for services ▪ Agree that beneficiary will not wait longer than 20 minutes in the office before being tested

IMPORTANT TAX DOCUMENT
SUBSTITUTE FORM W-9

Request for Taxpayer Identification Number

As part of the contracting process, we are requesting that you complete this Substitute Form W-9. We are required by law to obtain this information from you when making a reportable payment to you. If you do not provide us with this information, your payments may be subject to federal income tax backup withholding. Also, if you do not provide us with this information, you may be subject to a penalty imposed by the Internal Revenue Service under Section 6723 of the Internal Revenue Code.

This information must be consistent with the data provided on Page 2 of the application (clinic information).

1. Taxpayer Name
   (To whom the check is payable) _____
   (A legal entity name if a corporation or partnership)

   Doing Business as:
   (A division name if a corporation or the name of the business if a sole proprietor) DBA _____

2. Taxpayer Address _____
   _____
   _____

3. Taxpayer Identification Number
   a. Corporation _____
      (List employer identification number)
   b. Partnership _____
      (List employer identification number)
   c. Sole Proprietorship _____
      (List social security number or employer identification number)
   d. Tax Exempt Entity _____
      (List employer identification number)
   e. Other – Please Explain _____

4. Effective Date of Taxpayer Name and TIN _____

5. Form Completed By _____
   (Print name)

6. Signature _____
   (Signature)

7. Today's Date _____

8. Daytime Phone Number ( ) _____

PLEASE NOTE: INFORMATION REPORTED ON LINES 1-3 MUST BE CONSISTENT WITH DATA ON FILE WITH THE IRS AND SOCIAL SECURITY ADMINISTRATION.