Clinician tax ID number add/update form

TennCare Medicaid network only

Please use the following instructions to complete this form for the following requests:

- Modifications related to an existing tax ID number (TIN)
- Add a new TIN
- Inactivate a particular TIN

Once completed, you can submit the completed form to **uhccp_bhnetwork@uhc.com**.

Demographic changes only

To add, modify and/or delete a practice, remit, mailing, recredentialing and/or 1099 address and/or information, **please contact Provider Services at 800-690-1606** or notify your network account manager at **uhccp_bhnetwork@uhc.com**.

If you have questions, please contact your **regional network account manager**.

Note: To help prevent any disruptions to your network status, your CAQH application must match the information in your provider record. Modifications to your UnitedHealthcare Community Plan provider record do not automatically update CAQH. CAQH applications must be updated separately.

What would you like to do? (Select all applicable)	**Here's what is needed**
☐ **Add additional TIN and related practice information to your provider profile** **Note:** If you are inactivating a TIN, please also check the "Inactivate an existing TIN" box below.	Complete sections: 1, 2, 5, 6, 7
☐ **Change existing TIN name or number** ☐ **Includes demographics for new TIN**	Complete sections: 1, 3, 6 and 7 Also, complete section 2
☐ **Inactivate an existing TIN** **Note:** At least 1 active TIN must remain associated with your individual Agreement. If you wish to terminate your network participation, please refer to your network manual and Agreement for requirements.	Complete sections: 1, 4 and 7

TIN = tax ID number | **EIN** = employee ID number

United Healthcare Community Plan

Clinician tax ID number add/update form

1. Clinician detail (* required)		
Last name:*	First name:*	Middle initial:
NPI number – type I:*	Individual **taxonomy**:	
Cultural competency trained?* The Centers for Medicare & Medicaid Services (CMS) require that all persons who provide health care or administrative services to Medicare enrollees disclose whether cultural competency training has been completed.	Yes ☐ No ☐	

2. Demographics new TIN (* required)

Effective date of new TIN or TIN updates

Note: Effective dates should be no earlier than 30 calendar days prior to the date of submission and no greater than 90 days after submission. If the effective date is outside of these parameters, please include a reason for consideration.

Date:*	Reason (if applicable):
TIN:*	
TIN owner name as registered with IRS :*	
Clinic/DBA name (optional):	

Clinic/group level identifiers for this TIN	Number identifier	Issue state	Effective date	Expiration date
Group/clinic NPI number – type II		N/A	N/A	N/A
Organization/group Medicare number If applicable, effective date is required.		N/A		
Organization/group Medicaid number If applicable, effective date and state required.				

Mailing address (primary for TIN)*		
Mailing city:*	State:*	ZIP:*
Mailing phone:*	Contact name:* (Primary for TIN)	
Contact phone:*	General communications email:* (Must select one) ☐ Yes None ☐	

Public directory email:* (Must select one)
Your permission is required to display a public email address. By providing a public email address, you are attesting that this email address is routinely monitored and in compliance with all state and federal privacy laws and regulations. ☐ Yes None ☐

Website address to display in provider directory:* (Must select one)
☐ Yes None ☐

Remittance mailing address:*

Remittance city:*	State:*	ZIP:*

Remittance contact phone*

1099 mailing address (must match W9):* ☐ Same as remittance address

1099 city:*	State:*	ZIP:*

1099 contact phone:

Primary practice address for TIN (* required)
A single practice address must be designated as a primary practice for this TIN.

Identifiers	Abbreviation	Number identifier	Issue state	Effective date	Expiration date
License*					
DEA If applicable, effective and expiration dates are required.	N/A		N/A		
CDS (primary state) If applicable, effective date and state are required.	N/A				
Primary Medicare ID If applicable, effective is required.	N/A		N/A		
Primary Medicaid ID If applicable, effective date and state are required.	N/A				

Address:*	City:*	
County:*	State:*	ZIP:*
Appointment phone:*	General communication fax?* (Must select one) ☐ Yes No ☐	

Secure fax?* (Must select one)
A dedicated business 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). ☐ Yes None ☐

Inpatient only for this location?* Provider exclusively sees members in an inpatient setting. ☐ Yes ☐ No

In-home only for this location?*
Provider exclusively sees members in the member's place of residence. ☐ Yes ☐ No

Languages spoken by a qualified medical interpreter or other medical professional on staff at this location:

Practice hours*
Typical days and hours practiced at each location for this provider. Do not account for weekly variations.

Monday	From:		To:	
	From:		To:	
Tuesday	From:		To:	
	From:		To:	
Wednesday	From:		To:	
	From:		To:	
Thursday	From:		To:	
	From:		To:	
Friday	From:		To:	
	From:		To:	
Saturday	From:		To:	
	From:		To:	
Sunday	From:		To:	
	From:		To:	

Skilled medical interpreter service line?* (Must select one) ☐ Yes ☐ No

Express access at this location?* Offers routine appointments within 5 business days ☐ Yes ☐ No

Public transportation:* ☐ Yes ☐ No	Wheelchair accessibility:* ☐ Yes ☐ No

Wheelchair accessibility details

Parking:* ☐ Yes ☐ No	Exterior building:* ☐ Yes ☐ No
Interior building:* ☐ Yes ☐ No	Restroom:* ☐ Yes ☐ No
Exam room:* ☐ Yes ☐ No	Exam table/scale/chair:* ☐ Yes ☐ No

Wheelchair accessibility details (cont.)	
Gurneys and stretchers:* ☐ Yes ☐ No	Portable lifts:* ☐ Yes ☐ No
Radiologic equipment:* ☐ Yes ☐ No	Signage and documents:* ☐ Yes ☐ No

Additional (non-primary) practice location information No. 2

Identifiers	Abbreviation	Number identifier	Issue state	Effective date	Expiration date
License*					
DEA If applicable, effective and expiration dates are required.	N/A		N/A		
CDS (primary state) If applicable, effective date and state are required.	N/A				
Primary Medicare ID If applicable, effective is required.	N/A		N/A		
Primary Medicaid ID If applicable, effective date and state are required.	N/A				

Address:*	City:*	
County:*	State:*	ZIP:*
Appointment phone:*	General communication fax?* (Must select one) ☐ Yes No ☐	

Secure fax?* (Must select one)
A dedicated business 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). ☐ Yes None ☐

Inpatient only for this location?* Provider exclusively sees members in an inpatient setting. ☐ Yes ☐ No

In-home only for this location?*
Provider exclusively sees members in the member's place of residence. ☐ Yes ☐ No

Languages spoken by a qualified medical interpreter or other medical professional on staff at this location:

Practice hours*
Typical days and hours practiced at each location for this provider. Do not account for weekly variations.

Monday	From:		To:	
	From:		To:	
Tuesday	From:		To:	
	From:		To:	
Wednesday	From:		To:	
	From:		To:	
Thursday	From:		To:	
	From:		To:	
Friday	From:		To:	
	From:		To:	
Saturday	From:		To:	
	From:		To:	
Sunday	From:		To:	
	From:		To:	

Skilled medical interpreter service line?* (Must select one) ☐ Yes ☐ No

Express access at this location?* Offers routine appointments within 5 business days ☐ Yes ☐ No

Public transportation:* ☐ Yes ☐ No	Wheelchair accessibility:* ☐ Yes ☐ No

Wheelchair accessibility details

Parking:* ☐ Yes ☐ No	Exterior building:* ☐ Yes ☐ No
Interior building:* ☐ Yes ☐ No	Restroom:* ☐ Yes ☐ No
Exam room:* ☐ Yes ☐ No	Exam table/scale/chair:* ☐ Yes ☐ No
Gurneys and stretchers:* ☐ Yes ☐ No	Portable lifts:* ☐ Yes ☐ No
Radiologic equipment:* ☐ Yes ☐ No	Signage and documents:* ☐ Yes ☐ No

Additional (non-primary) practice location information No. 3					
Identifiers	**Abbreviation**	**Number identifier**	**Issue state**	**Effective date**	**Expiration date**
License*					
DEA If applicable, effective and expiration dates are required.	N/A		N/A		
CDS (primary state) If applicable, effective date and state are required.	N/A				
Primary Medicare ID If applicable, effective is required.	N/A		N/A		
Primary Medicaid ID If applicable, effective date and state are required.	N/A				

Address:*	City:*	
County:*	State:*	ZIP:*
Appointment phone:*	General communication fax? * (Must select one) ☐ Yes No ☐	

Secure fax?* (Must select one)
A dedicated business 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). ☐ Yes None ☐

Inpatient only for this location?* Provider exclusively sees members in an inpatient setting. ☐ Yes ☐ No

In-home only for this location?*
Provider exclusively sees members in the member's place of residence. ☐ Yes ☐ No

Languages spoken by a qualified medical interpreter or other medical professional on staff at this location:

Practice hours*
Typical days and hours practiced at each location for this provider. Do not account for weekly variations.

Monday	From:		To:	
	From:		To:	
Tuesday	From:		To:	
	From:		To:	
Wednesday	From:		To:	
	From:		To:	
Thursday	From:		To:	
	From:		To:	
Friday	From:		To:	
	From:		To:	
Saturday	From:		To:	
	From:		To:	
Sunday	From:		To:	
	From:		To:	

Skilled medical interpreter service line?* (Must select one) ☐ Yes ☐ No

Express access at this location?* Offers routine appointments within 5 business days ☐ Yes ☐ No

Public transportation:* ☐ Yes ☐ No	Wheelchair accessibility:* ☐ Yes ☐ No

Wheelchair accessibility details

Parking:* ☐ Yes ☐ No	Exterior building:* ☐ Yes ☐ No
Interior building:* ☐ Yes ☐ No	Restroom:* ☐ Yes ☐ No
Exam room:* ☐ Yes ☐ No	Exam table/scale/chair:* ☐ Yes ☐ No
Gurneys and stretchers:* ☐ Yes ☐ No	Portable lifts:* ☐ Yes ☐ No
Radiologic equipment:* ☐ Yes ☐ No	Signage and documents:* ☐ Yes ☐ No

Additional (non-primary) practice location information No. 4					
Identifiers	**Abbreviation**	**Number identifier**	**Issue state**	**Effective date**	**Expiration date**
License*					
DEA If applicable, effective and expiration dates are required.	N/A		N/A		
CDS (primary state) If applicable, effective date and state are required.	N/A				
Primary Medicare ID If applicable, effective is required.	N/A		N/A		
Primary Medicaid ID If applicable, effective date and state are required.	N/A				

Address:*	City:*	
County:*	State:*	ZIP:*
Appointment phone:*	General communication fax?* (Must select one) ☐ Yes ☐ No	

Secure fax?* (Must select one)
A dedicated business 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). ☐ Yes ☐ None

Inpatient only for this location?* Provider exclusively sees members in an inpatient setting. ☐ Yes ☐ No

In-home only for this location?*
Provider exclusively sees members in the member's place of residence. ☐ Yes ☐ No

Languages spoken by a qualified medical interpreter or other medical professional on staff at this location:

Practice hours*
Typical days and hours practiced at each location for this provider. Do not account for weekly variations.

Monday	From:		To:	
	From:		To:	
Tuesday	From:		To:	
	From:		To:	
Wednesday	From:		To:	
	From:		To:	
Thursday	From:		To:	
	From:		To:	
Friday	From:		To:	
	From:		To:	
Saturday	From:		To:	
	From:		To:	
Sunday	From:		To:	
	From:		To:	

Skilled medical interpreter service line?* (Must select one) ☐ Yes ☐ No

Express access at this location?* Offers routine appointments within 5 business days ☐ Yes ☐ No

Public transportation:* ☐ Yes ☐ No	Wheelchair accessibility:* ☐ Yes ☐ No

Wheelchair accessibility details

Parking:* ☐ Yes ☐ No	Exterior building:* ☐ Yes ☐ No
Interior building:* ☐ Yes ☐ No	Restroom:* ☐ Yes ☐ No
Exam room:* ☐ Yes ☐ No	Exam table/scale/chair:* ☐ Yes ☐ No
Gurneys and stretchers:* ☐ Yes ☐ No	Portable lifts:* ☐ Yes ☐ No
Radiologic equipment:* ☐ Yes ☐ No	Signage and documents:* ☐ Yes ☐ No

Additional (non-primary) practice location information No. 5					
Identifiers	**Abbreviation**	**Number identifier**	**Issue state**	**Effective date**	**Expiration date**
License*					
DEA If applicable, effective and expiration dates are required.	N/A		N/A		
CDS (primary state) If applicable, effective date and state are required.	N/A				
Primary Medicare ID If applicable, effective is required.	N/A		N/A		
Primary Medicaid ID If applicable, effective date and state are required.	N/A				

Address:*	City:*	
County:*	State:*	ZIP:*
Appointment phone:*	General communication fax?* (Must select one) ☐ Yes No ☐	

Secure fax?* (Must select one)
A dedicated business 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). ☐ Yes None ☐

Inpatient only for this location?* Provider exclusively sees members in an inpatient setting. ☐ Yes ☐ No

In-home only for this location?*
Provider exclusively sees members in the member's place of residence. ☐ Yes ☐ No

Languages spoken by a qualified medical interpreter or other medical professional on staff at this location:

3. Change existing TIN to a new TIN (at least 1 selection is required*)	
Requested change(s)	☐ **TIN name only (Line 1 of W9)**
	Old check name:
	New check name:
	☐ **TIN number only**
	Old number:
	New number:
	☐ **Both check name and number only**
	Old check name:
	New check name:

TIN owner name as registered with IRS:*	New TIN effective date:*

List any locations at which you are no longer practicing (street address line 1 is sufficient):

Please email the completed/signed and dated Substitute Form W-9 below to **uhccp_bhnetwork@uhc.com**. (*required)

4. Inactivate an existing TIN* (required if section is applicable)	
TIN(s) under which you are no longer practicing:	
Note: At least 1 active TIN must remain associated with your individual Agreement. If you wish to terminate your network participation, please refer to your network manual and Agreement for requirements.	☐ **1. TIN***
	a. Reason:*
	b. Effective date:*
	☐ **2. TIN***
	a. Reason:*
	b. Effective date:*

5. Authorization and release

UnitedHealthcare Community Plan (UHCCP) for behavioral health services authorization and release

I understand and acknowledge that I am changing information related to my participation status with UHCCP and that I am responsible for providing all information reasonably requested by UHCCP.

I hereby certify that all information contained in this change application and all its attachments is accurate, true and complete. I understand that I retain the right to review any information submitted to UHCCP in support of my application.

I understand that it is my responsibility to promptly notify UHCCP of any changes or additions to the information contained in the application and that all the information provided during the application process is subject to UHCCP's investigation and review. I understand and agree that if any information contained in this application is determined to be false or constitutes a material misstatement, my application may be denied, or my participation status may be involuntarily terminated. I understand that in the event that my application is denied, or my participation status is terminated involuntarily, UHCCP may be required to submit a report to the National Practitioner Data Bank and to state licensing authorities.

I understand I have the right to review and correct erroneous information obtained by UHCCP to evaluate my application. This does not include references, recommendations or other peer-review protected information. The review must take place within 6 months of this application and corrections must be made in writing, within 30 days of the review.

By changing information related to my participation status, I hereby authorize UHCCP, its affiliates and successors, to obtain any information that may be relevant to an evaluation of my professional qualifications, ability and character to practice medicine, including information about disciplinary actions or other confidential or privileged information, and other credentials. I hereby authorize all individuals, institutions and entities with which I have been or am now associated, including but not limited to, educational institutions, hospitals, clinics and health plans, professional liability carriers, licensing boards, specialty boards, professional societies, government agencies, and any other pertinent sources, to provide any relevant information requested by UHCCP or its representatives. I also consent to the inspection by representatives of UHCCP of all facilities and/or documents that may be material to my request for participation status with UHCCP.

I hereby release from liability all individuals, institutions and entities and their respective agents for all acts performed in good faith and without malice in connection with the investigation and review of this application, my participation status with UHCCP and the release and exchange of information by such individuals, institutions and entities. This release shall be in addition to any other applicable immunity provided by state and federal law. UHCCP is bound by all state and federal confidentiality laws.

I understand and agree that the authorization and release given by me is irrevocable as long as I am a participating clinician with UHCCP. This authorization to obtain confidential information about me remains in effect until I notify UHCCP otherwise, in writing, except as otherwise provided under state law.

I further acknowledge that I have read and understand this Authorization and Release. By signing this attestation, I acknowledge that I have hospital admitting privileges in good standing, if applicable, and that I carry professional liability insurance coverage of at least $1,000,000/$3,000,000 as a physician or $1,000,000/$1,000,000 as a non-physician clinician.

I warrant that I have the authority to sign this application, on my own behalf, and on behalf of any entity or organization for which I am signing in a representative capacity. I understand that if this application is accepted by UHCCP, I will be bound by the terms of the Agreement, of which this application is a part. I have read and understand the terms of the Agreement, and agree to be bound by them, and accept the published rates for my level of licensure.

A copy of this document shall have the same effect as the original.

Printed name of applicant:*

Original signature of applicant:*

6. Substitute Form W-9

Important tax document – Substitute Form W-9

Request for tax ID 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 in Sections 1 and 2 above.

1. Taxpayer name* (To whom the check is payable)

(A legal entity name if a corporation or partnership)

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

DBA:

2. Taxpayer address*

City:	State:	ZIP:

(A legal entity name if a corporation or partnership)

3. Tax ID number (TIN)*

Corporation (List employer ID number)	
Partnership (List employer ID number)	
Sole proprietorship (List Social Security number or employer ID number)	
Tax exempt entity (List employer ID number)	
Other – Please explain	

4. Effective date of taxpayer name and TIN* with the IRS

Form completed by:*

Signature:

Today's date:*	Daytime phone number:*

Please note: Information reported on lines 1-3 above must be consistent with data on file with the IRS and Social Security Administration.

7. Attestation (*all items below required)	
Submitted by (full name):*	Title:*
Contact phone:*	Contact email:*
Signature:*	
The clinician or clinician representative certifies that all information provided on this form is true and correct to the best of their knowledge, and that it is free of any significant misstatements, misrepresentations or omissions.	