Join our network request submission: Ancillary providers and centers

Durable medical equipment, prosthetics, orthotics and supplies questionnaire

To request new or amended participation with our durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) network, complete this questionnaire with any required documentation and visit **UHCprovider.com/contact** to connect with us through chat for submission instructions.

Complete and submit this questionnaire if you are:

- An eligible DMEPOS provider looking for a new agreement with us and meet the following criteria:
  - You are located in a state with Any Willing Provider (AWP) requirement
  - Your agreement would fill a documented geographic access gap for specific DMEPOS services
  - You offer services not available through the network you currently participate in
- A current network DMEPOS provider requesting renegotiation or additional UnitedHealthcare network plan participation to your existing agreement

Go to **UHCprovider.com/join > Ancillary providers** for more details on joining our network, including required documentation, participation instructions and more.

Provider contact information	
Contact name:	Email address:

Provider information			
Tax ID number	**National provider identifier (NPI) number**	**Associated legal name**	**Legal DBAs affiliated with provider**

Servicing markets:			
Provider address:			
City:	State:	ZIP code:	Practice website URL:

Provider quality attestation

Please select the boxes next to the following that the provider is accredited through. The provider must be in good standing with the accreditation program as a Medicare-certified provider. Attach a copy of each facility accreditation with your submission.

- ☐ **Accreditation Commission for Health Care**
  Respiratory, complex rehab, custom orthotics/prosthetics, therapeutic shoes, ocular prostheses
- ☐ **American Board for Certification in Orthotics & Prosthetics, Inc.**
  Respiratory, complex rehab, custom orthotics/prosthetics, therapeutic shoes, ocular prostheses
- ☐ **Board of Certification/Accreditation International**
  Respiratory, complex rehab, custom orthotics/prosthetics, therapeutic shoes, ocular prostheses
- ☐ **Commission on Accreditation of Rehabilitation Facilities (CARF)**
  Respiratory, complex rehab, custom orthotics/prosthetics, therapeutic shoes, ocular prostheses
- ☐ **Community Health Accreditation Program (CHAP)**
  Respiratory, complex rehab, custom orthotics/prosthetics, therapeutic shoes, ocular prostheses
- ☐ **Healthcare Quality Association on Accreditation (HQAA)**
  Respiratory, complex rehab, custom orthotics/prosthetics, therapeutic shoes, ocular prostheses

My initials attest that the requesters **facility** is a Medicare-certified provider in good standing. Requester's **facility** is accredited by the following for services being requested. Provide copy of **facility** accreditation. Initials:

- ☐ **National Association of Boards of Pharmacy**
  Respiratory, breast prosthetics, therapeutic shoes/inserts
- ☐ **The Compliance Team, Inc.**
  Respiratory, complex rehab, custom orthotics/prosthetics, therapeutic shoes, ocular prostheses
- ☐ **The Joint Commission**
  Respiratory, complex rehab, custom orthotics/prosthetics, therapeutic shoes, ocular prostheses

Type of participation agreement requested

Check all that apply:

☐ UnitedHealthcare commercial plans ☐ UnitedHealthcare® Medicare Advantage
☐ UnitedHealthcare Community Plan (Medicaid) ☐ State abbreviation

Medicaid number:

Medicare number:

Existing network provider:

Current contract termination date:	Current contract termination notice date:

Current contracted fee schedule:

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Services provided			
Identify the provider's top 3 specialties and annual UnitedHealthcare claim volume (in thousands) for those specialties			
Bone growth	$	Negative pressure wound therapy	$
Breast pump	$	Orthotics	$
Complex rehab	$	Ostomy	$
Continuous passive motion (CPM)	$	Pneumatic compression	$
Diabetic shoes	$	Prosthetics	$
Diabetic testing	$	Respiratory	$
Durable medical equipment (DME) and supplies	$	Respiratory vest	$
Dynamic splinting	$	Speech generating device	$
Enteral	$	Transcutaneous electrical nerve stimulation (TENS)	$
Incontinence	$	Urology	$
Insulin therapy	$	Other (specify)	$

Place of service address:	
Counties served:	**Languages spoken:**

Attestation	
I attest that the provided in this document is true and correct.	
Signature:	
Printed name:	Title:
Date signed:	

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