# Join our network request submission: Ancillary providers and centers

## Independent diagnostic testing facilities questionnaire

To join our independent diagnostic testing facilities (IDTF) network, complete this questionnaire with any required documentation and visit **UHCprovider.com/contact** to connect with us through chat for submission instructions. An incomplete questionnaire or missing documentation may cause contracting delays.

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

| **Questionnaire completed by** | |
|---|---|
| Name: | Title: |
| Phone: | Email address: |
| Date completed: | |

| **Required attachments** |
|---|
| ☐ Copy of Form W-9 signed within the last 3 months |
| ☐ Copy of current state license (if applicable) |
| ☐ Copy of Certificate(s) of Insurance (COI) for medical malpractice policy/policies |
| ☐ Copy of COI(s) for comprehensive general liability insurance policy/policies |
| ☐ Certificate or of accreditation for your location(s), if applicable |
| ☐ Completed roster (excel sheet), if applicable |

| **Legal owners** |
|---|
| Identify all names of legal owners and percent of ownership |

| **DBA** | |
|---|---|
| Name: | Phone: |
| Address: | |

| **Contracting contact, if different that individual completing questionnaire** | |
|---|---|
| Name: | Phone: |
| Address (if different): | |

| **Taxonomy codes** |
|---|
| |



United Healthcare®

## Current UnitedHealthcare participation status

| | |
|---|---|
| ☐ UnitedHealthcare commercial plans | State(s): |
| ☐ UnitedHealthcare® Medicare Advantage | State(s): |
| ☐ UnitedHealthcare Community Plan (Medicaid) | State(s): |
| ☐ Doesn't participate in any of the plans listed above | |

## Participation IDs

Medicare ID:

Community Plan (Medicaid) ID:

## Billing

Address:

| | |
|---|---|
| Phone: | Fax: |

## Do you have multiple service locations?

☐ No; move to next section ☐ Yes. Download, complete and save **roster** for submission with completed questionnaire, if required.

## Facility's claim preference

All claims must be submitted using the following selection to help avoid claim delays or denials. Any changes in billing submission type must be reported to us to for contractual amendment. Failure to do so can result in processing delays and/or claims denials.

☐ 1500 (HCFA 1500 / CMS-1500 / 1500 HICF) ☐ UB (UB92 / UB04)

## Advanced imaging accreditation

If this location performs advanced imaging (e.g., CT, MRI, MRA, PET or nuclear medicine), please indicate if this location has been reviewed by any of the following accrediting authorities. Please also include a copy of the most recent accreditation report.

☐ American College of Radiology (ACR)
☐ The Joint Commission (TJC)
☐ RadSite
☐ Intersocietal Accreditation Commission (IAC)
☐ N/A (this location doesn't perform advanced imaging)

Is accreditation report attached? ☐ Yes ☐ No

## IDTF overview

Please describe the complete nature of your IDTF: