

Join our network request submission: Ancillary providers and centers

Freestanding laboratory

To join our network as a freestanding laboratory, complete this questionnaire with any required documentation and visit UHCprovider.com/contact to connect with us through chat for submission instructions.

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

| | |
|---|----------------------|
| Facility legal name: | Tax ID number (TIN): |
| National Provider Identifier (NPI) number: | DBA: |
| Contact name and title: | |
| Billing/mailling address: | |
| Physical address (if different): | |
| Phone: | Fax: |
| Email: | Claims valuation: |
| Practice website URL: | CLIA number: |
| Insurance summary of limits: | |
| College of American Pathologists certified: Yes No | |
| Have you successfully completed the UnitedHealthcare credentialing process? | |
| Yes (If yes, date approved) | No |

States and territories you can offer services in:

| | | | | | | | |
|----|----|----|----|----|----|----|----|
| AL | CT | ID | ME | MT | NC | PR | VT |
| AK | DE | IL | MD | NE | ND | RI | VA |
| AZ | DC | IN | MA | NV | MP | SC | VI |
| AR | FL | IA | MI | NH | OH | SD | WA |
| AS | GA | KS | MN | NJ | OK | TN | WV |
| CA | GU | KY | MS | NM | OR | TX | WI |
| CO | HI | LA | MO | NY | PA | UT | WY |

States and territories you have Medicaid certification in:

| | | | | | | | |
|----|----|----|----|----|----|----|----|
| AL | CT | ID | ME | MT | NC | PR | VT |
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| AZ | DC | IN | MA | NV | MP | SC | VI |
| AR | FL | IA | MI | NH | OH | SD | WA |
| AS | GA | KS | MN | NJ | OK | TN | WV |
| CA | GU | KY | MS | NM | OR | TX | WI |
| CO | HI | LA | MO | NY | PA | UT | WY |

Does your organization have Medicaid ID numbers for all service locations? Yes No

Does your organization have Medicare certification for all service locations? Yes No

Please check all lab services offered by your lab:

Anatomic pathology (88000-88099)
Chemistry (82000-84999)
Consultations (clinical pathology) (80500-80502)
Cytogenetic studies (88230-88299)
Cytopathology (88104-88199)
Drug testing (80100-80103)
Evocative/suppression testing (80400-80440)
Hematology and coagulation (85002-85999)
Immunology (86000-86849)
In vitro transcutaneous lab procedures (88720-88741)

Microbiology (87001-87999)
Organ or disease-oriented panels (80047-80076)
Other procedures (89049-89240)
Reproductive medicine procedures (89250-89398)
Surgical pathology (88300-88399)
Therapeutic drug assays (80150-80299)
Tissue typing (86805-86849)
Transfusion medicine (86850-86999)

Does your lab offer tests that are proprietary or exclusive to your laboratory?

Yes (If yes, provide a description of the test, indications for use, the FDA registration or FEI number and the FDA proprietary name.)

No

Does your lab offer hospital-based pathology services?

Yes (If yes, include a list of hospitals (name and location) your lab services.)

No

Does your lab send out tests to other labs to be performed?

Yes (If yes, include a list of tests and where the test is sent.)

No

Can you submit test results in HL7 v2.5.1 format with reference ranges and LOINC codes (where assigned)? Yes No



Is the lab associated with a health system?

Yes (If yes, provide the hospital system name:)

What tests are performed inpatient? % , outpatient % , non-patient %

No

Are lab services covered under the Health System Agreement? Yes No

Does your facility have HITRUST, SOC2 Level 2 or other data security certification?

Yes (If yes, include certification documents demonstrating the level of information security maintained in the lab and administrative systems.)

No

States and territories you can offer services in:

| | | | | | | | |
|----|----|----|----|----|----|----|----|
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| AZ | DC | IN | MA | NV | MP | SC | VI |
| AR | FL | IA | MI | NH | OH | SD | WA |
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| CA | GU | KY | MS | NM | OR | TX | WI |
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How does your facility submit claims?

| | |
|----------|----------------------------|
| CMS-1500 | Professional services only |
| HCFA | Technical services |
| UB-94 | Only global billing |

Please list claims dollars paid to you by UnitedHealthcare and/or its affiliated companies, whether participating or non-participating, for the past 12 months:

Amount: Paid from to (date range)

Professional liability/malpractice liability insurance

Corporate entity on declaration sheet:

| | | |
|------------------------------------|-------------------------------|------------------|
| Carrier name: | Effective date: | Expiration date: |
| Amount of coverage per occurrence: | Amount of coverage aggregate: | |

Acceptable forms of accreditation (check all that apply and provide copy of the certification(s)):

- American Commission for Health Care, Inc. (ACHC)
- College of American Pathologists (CAP)
- Commission on Office Laboratory Accreditation (COLA)
- Community Health Accreditation Program (CHAP)
- Joint Commission on Accreditation of Healthcare Organization (JCAHO)
- CMS (Medicare/Medicaid) or state agency review or certification
- National Committee for Quality Assurance (NCQA)
- California Department of Public Health license (CA ID)
- Clinical Laboratory Improvement Amendments (CLIA) (include certification including lab certification code(s) for the approved tests)
- Clinical Laboratory Evaluation Program (CLEP)
- Other:

Has the facility been reviewed for accreditation? Yes No

If yes, please answer the following questions:

Name of accreditation organization: _____

What were the results of the review? _____

Approved Denied Provisional

What was the date of last approval? _____ Year of your next scheduled survey? _____

If facility was denied or received a provisional accreditation, please explain. _____

Has facility been reviewed for Medicare certification? _____

Yes (If yes, date of last site visit?) No

Signature: _____

| | |
|---------------------|--------------|
| Printed name: _____ | Title: _____ |
|---------------------|--------------|

I attest that information entered is accurate and valid and that I have attestation authority.

Insurance coverage provided by or through UnitedHealthcare Insurance Company or its affiliates. Health plan coverage provided by UnitedHealthcare of Arizona, Inc., UHC of California DBA UnitedHealthcare of California, UnitedHealthcare Benefits Plan of California, UnitedHealthcare of Colorado, Inc., UnitedHealthcare of the Mid-Atlantic, Inc., MAMSI Life and Health Insurance Company, UnitedHealthcare of New York, Inc., UnitedHealthcare Insurance Company of New York, UnitedHealthcare of Oklahoma, Inc., UnitedHealthcare of Oregon, Inc., UnitedHealthcare of Pennsylvania, Inc., UnitedHealthcare of Texas, Inc., UnitedHealthcare Benefits of Texas, Inc., UnitedHealthcare of Utah, Inc., UnitedHealthcare of Washington, Inc., Optimum Choice, Inc., Oxford Health Insurance, Inc., Oxford Health Plans (NJ), Oxford Health Plans (CT), Inc., All Savers Insurance Company, Tufts Health Freedom Insurance Company or other affiliates. Administrative services provided by OptumHealth Care Solutions, LLC, OptumRx, Oxford Health Plans LLC, United HealthCare Services, Inc., Tufts Health Freedom Insurance Company or other affiliates. Behavioral health products provided by U.S. Behavioral Health Plan, California (USBHPC), United Behavioral Health (UBH), or its affiliates.

