UnitedHealthcare Community Plan

TennCare Medicaid Network Only
Clinician Tax ID - Add / Update Form

PLEASE FOLLOW THE DIRECTIONS BELOW:

- **Complete this form to request** –
  - Modifications related to an existing Tax ID number
  - Add a new Tax ID Number
  - Inactivate a particular Tax ID number

- **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**: CAQH Application needs to match the information in your Provider Record to prevent any disruptions in your network status. Modifications to your UHCCP 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 TAX ID AND RELATED PRACTICE INFO TO YOUR PROVIDER PROFILE** **Note:** *If you are also inactivating a Tax ID, please also check "Inactivate An Existing Tax ID" in the box below.*	Complete sections: 1, 2, 5, 6, 7
☐ **CHANGE EXISTING TAX ID NAME OR NUMBER** ☐ **Includes Demographics for new Tax ID**	Complete Sections: 1, 3, 6 & 7 Also, complete section: 2
☐ **INACTIVATE AN EXISTING TAX ID** **Note:** *At least one active Tax ID **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 & 7

Tax ID = Tax Identification Number - EIN = Employee Identification Number

1. Clinician Detail (* Required)

Last Name *		**First Name***		**Middle Initial**	
NPI (Type I) *					
Individual Taxonomy					
Cultural Competency Trained? * The Centers for Medicare and 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 Tax ID (* Required)

Effective Date of New/Updates for this Tax ID **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 effective date is outside of these parameters, please include a reason for consideration.*

Date *		**Reason** (if applicable)	
Tax ID Number *			
Tax ID Owner Name as Registered with IRS *			
Clinic / DBA Name (Optional)			

Clinic/Group Level Identifiers for this Tax ID	Number Identifier	Issue State	Effective Date	Expiration Date
Group/Clinic NPI - Type II		N/A	N/A	N/A
Organization/Group Medicare Number (If applicable Eff is required)		N/A		
Organization/Group Medicaid Number (If applicable Eff date & state req'd)				

Mailing Address (Primary for Tax ID)*			
Mailing City / State / Zip *		**Mailing Address Phone** *	
Contact Name *(Primary for Tax ID)		**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 Remit**			
1099 City / State / Zip*		**1099 Contact Phone***	

PRIMARY PRACTICE ADDRESS FOR Tax ID (*Required) -
A single practice address must be designated as a 'primary' practice for this Tax ID

Identifiers	Abbreviation	Number Identifier	Issue State	Effective Date	Expiration Date
License*					
DEA (If applicable, Eff & Expire Dates are required)	N/A		N/A		
CDS (Primary State) (If applicable, Eff Date & State are required)	N/A				
Primary Medicare ID (If applicable, Eff Date is required)	N/A		N/A		
Primary Medicaid ID (If applicable, Eff Date & State are required)	N/A				

Address *		**Practice Hours*** Typical days and hours practiced at each location for this provider. Do not account for weekly variations.					
City *		**County ***		Monday	From		To
					From		To
State *		**Zip ***		Tuesday	From		To
					From		To
Appointment Phone *				Wednesday	From		To
					From		To
General Communication Fax? * <Must select one>	☐ Yes <Fax Number>			Thursday	From		To
	☐ No				From		To
Secure Fax * <Must select one> 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).	☐ Yes <Fax Number>			Friday	From		To
					From		To
	☐ No			Saturday	From		To
					From		To
Inpatient Only for this location? * Provider exclusively sees members in an inpatient setting.	☐ Yes ☐ No			Sunday	From		To
					From		To
In-Home Only for this location?* Provider exclusively sees members in the members place of residence.	☐ Yes ☐ No	**Skilled Medical Line Interpreter Service *** <Must select one>			☐ Yes ☐ No		
Languages spoken by a qualified medical interpreter or other medical professional on staff at this location							
Express Access at this location * Offers routine appointments within five 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 & Stretchers*	☐ Yes ☐ No	**Portable Lifts***	☐ Yes ☐ No
Radiologic Equipment *	☐ Yes ☐ No	**Signage & Documents***	☐ Yes ☐ No

ADDITIONAL (NON-PRIMARY) PRACTICE LOCATION INFORMATION # 2

Does the state for this location differ from the Primary address? *			☐ Yes	☐ No		
Identifiers	**Abbreviation**	**Number Identifier**	**Issue State**	**Effective Date**	**Expiration Date**	
License *						
DEA (If applicable, Eff & Expire Dates are required)	N/A		N/A			
CDS (Primary State) (If applicable, Eff Date & State are required)	N/A					
Primary Medicare ID (If applicable, Eff Date is required)	N/A		N/A			
Primary Medicaid ID (If applicable, Eff Date & State are required)	N/A					

Address *		**Practice Hours*** Typical days and hours practiced at each location for this provider. Do not account for weekly variations.					
City *		**County ***		Monday	From		To
					From		To
State *		**Zip ***		Tuesday	From		To
					From		To
Appointment Phone *				Wednesday	From		To
					From		To
General Communication Fax? * <Must select one>	☐ Yes <Fax Number>			Thursday	From		To
	☐ No				From		To
Secure Fax * <Must select one> 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).	☐ Yes <Fax Number>			Friday	From		To
					From		To
	☐ No			Saturday	From		To
					From		To
Inpatient Only for this location? * Provider exclusively sees members in an inpatient setting.	☐ Yes ☐ No			Sunday	From		To
					From		To
In-Home Only for this location?* Provider exclusively sees members in the members place of residence.	☐ Yes ☐ No	**Skilled Medical Line Interpreter Service *** <Must select one>	☐ Yes ☐ No				
Languages spoken by a qualified medical interpreter or other medical professional on staff at this location							

Express Access at this location * Offers routine appointments within five 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 & Stretchers*	☐ Yes ☐ No	**Portable Lifts***	☐ Yes ☐ No
Radiologic Equipment *	☐ Yes ☐ No	**Signage & Documents***	☐ Yes ☐ No

ADDITIONAL (NON-PRIMARY) PRACTICE LOCATION INFORMATION # 3

Does the state for this location differ from the Primary address? *	☐ Yes ☐ No

Identifiers	**Abbreviation**	**Number Identifier**	**Issue State**	**Effective Date**	**Expiration Date**
License *					
DEA (If applicable, Eff & Expire Dates are required)	N/A		N/A		
CDS (Primary State) (If applicable, Eff Date & State are required)	N/A				
Primary Medicare ID (If applicable, Eff Date is required)	N/A		N/A		
Primary Medicaid ID (If applicable, Eff Date & State are required)	N/A				

Address *		**Practice Hours*** Typical days and hours practiced at each location for this provider. Do not account for weekly variations.				
City *		**County ***		Monday	From	To
					From	To
State *		**Zip ***		Tuesday	From	To
					From	To
Appointment Phone *				Wednesday	From	To
					From	To
General Communication Fax? * <Must select one>	☐ Yes <Fax Number>			Thursday	From	To
	☐ No				From	To
Secure Fax * <Must select one> 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).	☐ Yes <Fax Number>			Friday	From	To
	☐ No				From	To
				Saturday	From	To
					From	To
Inpatient Only for this location? * Provider exclusively sees members in an inpatient setting.	☐ Yes ☐ No			Sunday	From	To
					From	To
In-Home Only for this location?* Provider exclusively sees members in the members place of residence.	☐ Yes ☐ No	**Skilled Medical Line Interpreter Service *** <Must select one>	☐ Yes ☐ No			
Languages spoken by a qualified medical interpreter or other medical professional on staff at this location						

Express Access at this location * Offers routine appointments within five 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 & Stretchers*	☐ Yes ☐ No	**Portable Lifts***	☐ Yes ☐ No
Radiologic Equipment *	☐ Yes ☐ No	**Signage & Documents***	☐ Yes ☐ No

ADDITIONAL (NON-PRIMARY) PRACTICE LOCATION INFORMATION # 4

Does the state for this location differ from the Primary address? *	☐ Yes ☐ No

Identifiers	**Abbreviation**	**Number Identifier**	**Issue State**	**Effective Date**	**Expiration Date**
License *					
DEA (If applicable, Eff & Expire Dates are required)	N/A		N/A		
CDS (Primary State) (If applicable, Eff Date & State are required)	N/A				
Primary Medicare ID (If applicable, Eff Date is required)	N/A		N/A		
Primary Medicaid ID (If applicable, Eff Date & State are required)	N/A				

Address *		**Practice Hours*** Typical days and hours practiced at each location for this provider. Do not account for weekly variations.				
City *		**County ***		Monday	From	To
					From	To
State *		**Zip ***		Tuesday	From	To
					From	To
Appointment Phone *				Wednesday	From	To
					From	To
General Communication Fax? * <Must select one>	☐ Yes <Fax Number>			Thursday	From	To
	☐ No				From	To
Secure Fax * <Must select one> 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).	☐ Yes <Fax Number>			Friday	From	To
	☐ No				From	To
				Saturday	From	To
					From	To
Inpatient Only for this location? * Provider exclusively sees members in an inpatient setting.	☐ Yes ☐ No			Sunday	From	To
					From	To
In-Home Only for this location?* Provider exclusively sees members in the members place of residence.	☐ Yes ☐ No	**Skilled Medical Line Interpreter Service *** <Must select one>	☐ Yes ☐ No			
Languages spoken by a qualified medical interpreter or other medical professional on staff at this location						

Express Access at this location * Offers routine appointments within five 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 & Stretchers*	☐ Yes ☐ No	**Portable Lifts***	☐ Yes ☐ No
Radiologic Equipment *	☐ Yes ☐ No	**Signage & Documents***	☐ Yes ☐ No

ADDITIONAL (NON-PRIMARY) PRACTICE LOCATION INFORMATION # 5

Does the state for this location differ from the Primary address? *	☐ Yes ☐ No

Identifiers	**Abbreviation**	**Number Identifier**	**Issue State**	**Effective Date**	**Expiration Date**
License *					
DEA (If applicable, Eff & Expire Dates are required)	N/A		N/A		
CDS (Primary State) (If applicable, Eff Date & State are required)	N/A				
Primary Medicare ID (If applicable, Eff Date is required)	N/A		N/A		
Primary Medicaid ID (If applicable, Eff Date & State are required)	N/A				

Address *		**Practice Hours*** Typical days and hours practiced at each location for this provider. Do not account for weekly variations.				
City *		**County ***		Monday	From	To
					From	To
State *		**Zip ***		Tuesday	From	To
					From	To
Appointment Phone *				Wednesday	From	To
					From	To
General Communication Fax? * <Must select one>	☐ Yes <Fax Number> ☐ No			Thursday	From	To
					From	To
Secure Fax * <Must select one> 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).	☐ Yes <Fax Number> ☐ No			Friday	From	To
					From	To
				Saturday	From	To
					From	To
Inpatient Only for this location? * Provider exclusively sees members in an inpatient setting.	☐ Yes ☐ No			Sunday	From	To
					From	To
In-Home Only for this location?* Provider exclusively sees members in the members place of residence.	☐ Yes ☐ No	**Skilled Medical Line Interpreter Service *** <Must select one>	☐ Yes ☐ No			
Languages spoken by a qualified medical interpreter or other medical professional on staff at this location						

Express Access at this location * Offers routine appointments within five 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 & Stretchers*	☐ Yes ☐ No	**Portable Lifts***	☐ Yes ☐ No
Radiologic Equipment *	☐ Yes ☐ No	**Signage & Documents***	☐ Yes ☐ No

3. CHANGE EXISTING TAX ID TO A NEW TAX ID - At least one selection is Required *

Requested Change(s)	☐ Tax ID Name Only (Line 1 of W9)
	Old Check Name
	New Check Name
	☐ Tax ID Number Only
	Old Number
	New Number
	☐ Both Check Name and Number Only
	Old Check Name
	New Check Name
	Old Number
	New Number
Tax ID Owner Name as Registered with IRS *	
New Tax ID Effective Date*	
List any locations at which you are no longer practicing: (street address line 1 is sufficient)	

Attach completed/signed & dated SUBSTITUTE FORM W-9 below - (Required) *

4. INACTIVATE AN EXISTING TAX ID * Required if section is applicable

Tax ID Number(s) under which you are no longer practicing:	(1) Tax ID *	
	a. Reason *	
Note: At least one active Tax ID 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.	b. Effective Date *	
	(2) Tax ID *	
	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 from liability 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 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 in Section 1 & 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)

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 & TIN* with the IRS _____

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 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.