OPTUM Care® | Network of Utah

The Utah Provider Roster should be completed when submitting provider demographics updates, additions or terminations. Make sure all information is complete as we cannot process an incomplete roster. Completed rosters can be sent to lcdcontractutah@optum.com or faxed to 1-855-493-2865.

Tax ID	National Provider Identification Number (NPI)	Last Name	First Name	Middle Name

Provider's Identifying Information				
Name Suffix (if applicable)	Degree	NUCC Taxonomy Code	CAQH ID Number	DME Provider Number (PTAN)

		Business/Practice Information		
To Be Credentialed? (yes/no)	**Gender**	**Name of Legal Owner of Tax ID Number**	**Group/Site Location Name DBA**	**Address Type (Enter a separate line for each address type)** P = Practice B = Billing M = Mail Only D = Credentialing Only

Is this address the provider's primary or secondary practice address? (Primary or Secondary)	Address	Address Suite	City	County

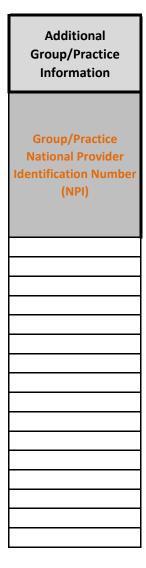| | | | **Address - Use one row for each** | |
| | | | **Please use 1 row per Tax ID # per address** | |
State	**Zip Code** (00000)	**Phone Number** (000-000-0000)	**Should Address appear in the Directory** (Y or N) (Default to YES, if not provided)	**Fax Number** (000-000-0000)

Days of Office Operation	Office Hours at this Address (Default to M-F 8am- 5pm, if not provided)	Email Address of Provider	Web Address	Is this Location Handicap Accessible? (Y or N)

	Medicaid and Medicare Provider Information	

First Additional Language Spoken at this Location (English will be listed as default, unless otherwise noted)	Second Additional Language Spoken at this Location (leave blank if none)	Language Spoken By P = Provider S = Staff B = Both	Medicaid Number for this Provider (If group participates in Medicaid Products, this is a mandatory field)	Medicare Number for this Provider

Specialty 1 Information		Specialty 2 Information		Specialty 3
Practicing Specialty 1	**Should this Specialty appear in the directory?** (Y or N) (Will default to YES, if not provided)	**Practicing Specialty 2**	**Should Specialty 2 appear in the directory?** (Y or N) (Will default to YES, if not provided)	**Practicing Specialty 3**

Information	New Patient Status	Specific Specialty Details		CLIA Certification Medicaid On
Should Specialty 3 appear in the directory? (Y or N) (Will default to YES, if not provided)	**Accepting new patients?** **Y: Yes** **N: No** **E: Existing Only** (Will default to YES, if not provided)	**Is this Provider a PCP, Specialist, Hospitalist or Hospital Based Provider** (PCP, Spec, Hosp or HBP.)	**Supervising Physician** (Required For all Mid-Level Providers Only)	**Does your office location perform In-Office Lab procedures?** (Y or N)

on Information nly Products	Hospital Affiliation - Use one row for each		Products Opt In/Out (only applies if your group has the option to opt in/out of certain products)	
CLIA Certification Number (Required for Medicaid for practitioner providing lab services within office setting)	Hospital Privileges or Covering Arraignments (Y or N) Priv or arraignments are required for participation	Hospital Affiliation or Covering Group/Provider name	UnitedHealthcare Participating Provider? (if applies) (Y or N?)	Medicare Participating Provider? (if applies) (Y or N?)

Additional Group/Practice Information
Group/Practice National Provider Identification Number (NPI)

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Effective Date	Tax ID	National Provider Identification Number (NPI)	Last Name	First Name

Provider's Identifying Information

Middle Name	Name Suffix (if applicable)	Degree	NUCC Taxonomy Code	CAQH ID Number

	Business/Practice Information			
DME Provider Number (PTAN)	**Name of Legal Owner of Tax ID Number**	**Group/Site Location Name DBA**	**Address Type** P = Practice C = Billing and Practice M = Mail Only D = Credentialing Only	**Is this address the provider's primary or secondary practice address?** (Primary or Secondary)

Address	Address Suite	City	State	Zip Code (00000)

| Address - Use one row for each | | | | |
Please use 1 row per Tax ID # per address				
Phone Number (000-000-0000)	**Should Address appear in the Directory** (Y or N) (Default to YES, if not provided)	**Fax Number** (000-000-0000)	**Days of Office Operation**	**Office Hours at this Address** (Default to M-F 8am- 5pm, if not provided)

Email Address of Provider	Web Address	Is this Location Handicap Accessible? (Y or N)	First Additional Language Spoken at this Location (English will be listed as default, unless otherwise noted)	Second Additional Language Spoken at this Location (leave blank if none)

	Medicaid and Medicare Provider Information		Specialty 1 Information	
Language Spoken By P = Provider S = Staff B = Both	**Medicaid Number for this Provider** (If group participates in Medicaid Products, this is a mandatory field)	**Medicare Number for this Provider**	**Practicing Specialty 1**	**Should this Specialty appear in the directory?** (Y or N) (Will default to YES, if not provided)

Specialty 2 Information		Specialty 3 Information		New Patient Status
Practicing Specialty 2	Should Specialty 2 appear in the directory? (Y or N) (Will default to YES, if not provided)	Practicing Specialty 3	Should Specialty 3 appear in the directory? (Y or N) (Will default to YES, if not provided)	Accepting new patients? Y: Yes N: No E: Existing Only (Will default to YES, if not provided)

Specific Specialty Details		CLIA Certification Information Medicaid Only Products		Hospital A Use one ro
Is this Provider a PCP, Specialist, Hospitalist or Hospital Based Provider (PCP, Spec, Hosp or HBP.)	**Supervising Physician** (Required For all Mid-Level Providers Only)	**Does your office location perform In-Office Lab procedures?** (Y or N)	**CLIA Certification Number** (Required for Medicaid for practitioner providing lab services within office setting)	**Hospital Privileges or Covering Arraignments** (Y or N) Priv or arraignments are required for participation

Affiliation - w for each	Products Opt In/Out (only applies if your group has the option to opt in/out of certain products)		Additional Group/Practice Information
Hospital Affiliation or Covering Group/Provider name	UnitedHealthcare Participating Provider? (if applies) (Y or N?)	Medicare Participating Provider? (if applies) (Y or N?)	Group/Practice National Provider Identification Number (NPI)

Change Type R=Remove A=Add In addition to the required pieces of data, please indicate only the information that is being added or removed from an existing provider's record. Please do not supply full provider demographics. One line per transaction. PCP location terms need to include reassignment provider (see columns CT - DA)	Effective Date of Change (mm/dd/yyyy)

Non Credentialed Provider (Y or N)	Original Credentialing Committee Date (mm/dd/yyyy)	Latest Re-Appointment/ Re-Credentialing Committee Approval Date (mm/dd/yyyy) This date should not be a future forecasted date.	Effective Date Only required if, the provider start date is later than the Original Credentialing Committee Date	Tax ID

Last Name	First Name	Middle Name	Name Suffix (if applicable)

Degree	National Provider Identification Number (NPI)	Atypical Designation	NUCC Taxonomy Code	Date of Birth (mm/dd/yyyy)

Gender	Tax ID's Incorporation Status

Name of Legal Owner of Tax id Number

Practice Web Address	Consent to publish Practice Web Address (Y or N) (Publication of Practice Web Address will default to No, unless otherwise noted)	Group/Site Location Name DBA (Required for Michigan, Ohio & Texas Medicaid)

Group NPI	Address Type P = Practice C = Billing and Practice M = Mail Only D = Credentialing Only	Is this address the provider's primary or secondary practice address? (Primary or Secondary)

Address	Address	City	State

Zip Code (00000)	Phone Number (000-000-0000)	Should Address appear in the Directory (Y or N) (Default to YES, if not provided)	PCP Capacity: How many members will the Provider accept at this Place of Service location? (Required for OH Medicaid only)

Fax Number (000-000-0000)	Days of Office Operation	Office Hours at this Address (Default to M-F 8am-5pm, if not provided)	Extended Office Hours at this location	Email Address of Individual Provider

Consent to publish Individual Provider Email Address (Y or N) (Publication of Provider Email Address will default to No, unless otherwise noted)	Is this Location Handicap Accessible? (Y or N) Required for Ohio & Texas Medicaid	If a place of service location is Handicap Accessible, please list all available Handicapped Accessibility Services at the location It is acceptable to list multiple services, separated by comma	Languages Spoken at this Location (English will be listed as default, unless otherwise noted)	Language Spoken By P = Provider S = Staff B = Both I = Skilled Interpreter (Default to provider if not specified)

Languages Written at this Location (English will be listed as default, unless otherwise noted)	Language Written By P = Provider S = Staff B = Both	Contact Name	Contact Email Address	Contact Type (e.g. office manager, billing, credentialing, etc.)

Contact Phone/Fax Number	Billing Address	Billing Address	Billing City

Billing State	Billing Zip (00000)	Billing Phone Number	Billing Fax Number	Type of Cultural Competence Training Medicaid Only

Effective Date of Cultural Competency Training **Medicaid Only**	Expiration Date of Cultural Competency Training **Medicaid Only**	Cultural Competence Training type **Medicaid Only** **Rollover the comments for the Training Types**	Essential Community Provider (ECP): Provider serves predominantly low-income, medically underserved individuals **Medicaid Only** Y=Yes, is a designated ECP provider N=No, is not a designated ECP provider	Medicaid Number for this Provider (If group participates in Medicaid Products, this is a mandatory field)

Medicaid: State Issuing	Medicare Number for this Provider	Practicing Specialty 1	Is this the provider's Primary or Secondary Specialty? P = Primary S = Secondary	Should this specialty appear in the directory? (Y or N) (Default to YES, if not provided)

Board Certification Status C= Certified E= Eligible N=Not Certified X=Not Applicable	Board Certification Effective Date (mm/dd/yyyy) (Required if Board Certified)	Board Certification Expiration Date (mm/dd/yyyy) L= Lifetime Cert, please indicate 2999 (Required if Board Certified)	Accepting Patient Status, Required for All Provider Types Y or N? Applies to all Lines of Business, Refer to columns CN through CQ if status varies by Line of Business (Default to YES, if not provided)	Practicing Specialty 2

Is this the provider's Primary or Secondary Specialty? P = Primary S = Secondary	Should this specialty 2 appear in the directory? (Y or N) (Will default to YES, if Not provided)	Board Certification Status C= Certified E= Eligible N=Not Certified X=Not Applicable	Board Certification Effective Date (mm/dd/yyyy) (Required if Board Certified)	Board Certification Expiration Date (mm/dd/yyyy) L= Lifetime Cert, please indicate 2999 (Required if Board Certified)

Accepting Patient Status, Required for All Provider Types Y or N? Applies to all Lines of Business, Refer to columns CN through CQ if status varies by Line of Business (Default to YES, if not provided)	Is this Provider a PCP, Specialist, Hospitalist or Hospital Based Provider (PCP, Spec, Hosp or HBP) Providers listed as Hospitalist or HBP is confirmation the provider does not practice in an office setting	If PCP, can members be assigned to this provider? (Y or N)	Mid-level Supervising Specialty (provide the specialty, not provider name) (Required For all Mid-Level Provider Only)	Does your office location perform In-Office Lab procedures? (Y or N)

CLIA Certification Number (Required for Medicaid for practitioner provides lab services within office setting)	State License Number	State in which License is Held	State License Number Expiration Date	DEA Number

DEA Number Expiration Date	Does Provider have at least Hospital Admitting Privileges or Covering Arrangements (Y or N)	Name of Admitting Hospital Affiliation(s) or Covering Group/Provider name	Admitting Hospital Affiliation Status Roll over the header and see the Affiliation status types Status is not required if Provider has covering arrangements	Medical School

Medical School Completion Date	Patient Age Limits (required for Ohio providers)	Patient Gender Restrictions (required if member Gender Restrictions)	UnitedHealthcare Panel Status Commercial Product only For All Provider Types O = Open C = Closed E = Existing Only	Oxford Health Plan Panel Status For All Provider Types O = Open C = Closed E = Existing Only

Medicare Panel Status For All Provider Types O = Open C = Closed E = Existing Only	Medicaid Panel Status For All Provider Types O = Open C = Closed E = Existing Only	PCP Reassignment Provider Name #1	NPI Provider #1	Tax ID Provider #1

Group Name # 1	PCP Reassignment Provider Name #2	NPI Provider #2	Tax ID Provider #2	Group Name # 2

**Please note, all information labeled in Red print are required and must be completed or otherwise will be rejected	By submitting this form, you are affirming that the information listed below is complete and accurate.		
Termination Date (UHC)	**Reason for Termination** Select from listing- roll mouse over header (Default to Provider Left Group if left blank)	**Non Credentialed Provider (Y or N)**	**Tax ID**

	Provider's Identifying Information			
Last Name	**First Name**	**Middle Name**	**Suffix**	**Degree**

National Provider Identification Number (NPI)	PCP Reassignment Provider Name #1

PCP Reassignment Information

NPI Provider #1	Tax ID Provider #1	Group Name # 1

PCP Reassignment Provider Name #2	NPI Provider #2	Tax ID Provider #2	Group Name # 2