



Provider, _____ requests to participate with the following networks available through UnitedHealthcare:

_____ **UnitedHealthcare Community Plan (UHCCP)**

_____ **CoverKids Network- Children's Health Insurance Program (CHIP)** is a Federally sponsored program that provides medical and behavioral health insurance coverage to children under age 18 and pregnant women.

Printed Name of Provider/Group/Facility

Tax Identification Number/EIN

Provider- rendering service

NPI

TennCare ID

Authorized/Signature

Date

I (Provider or Group/Facility authorized facility representative as noted above) hereby attest that the information above is true and accurate to the best of my knowledge. I understand that any information provided pursuant to this attestation that is subsequently found to be untrue and/or incorrect could result in my termination from the UnitedHealthcare Community Plan network.