

# Join our network request submission - Ancillary providers and centers

Durable medical equipment, prosthetics, orthotics and supplies questionnaire

To request new or amended participation with our durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) network, email this completed questionnaire with any required documentation to [dmeponsnetwork@uhc.com](mailto:dmeponsnetwork@uhc.com).

## Complete and submit this questionnaire if you are:

- An eligible DMEPOS provider looking for a new agreement with us and meet the following criteria:
  - You are located in a state with Any Willing Provider (AWP) requirement
  - Your agreement would fill a documented geographic access gap for specific DMEPOS services
  - You offer services not available through the network you currently participate in
- A current network DMEPOS provider requesting renegotiation or additional UnitedHealthcare network plan participation to your existing agreement

Go to [UHCprovider.com/join](https://UHCprovider.com/join) > **Ancillary providers** for more details on joining our network, including required documentation, submission instructions and more.

## Provider contact information

Contact name:

Email address:

## Provider information

Tax ID number	National Provider Identified (NPI) number	Associated legal name	Legal DBAs affiliated with provider
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Servicing markets:

Provider address:

City:

State:

ZIP code:

Practice website URL:

## Provider quality attestation

Please select the boxes next to the following that the provider is accredited through. The provider must be in good standing with the accreditation program as a Medicare-certified provider. Attach a copy of each facility accreditation with your submission.

### Accreditation Commission for Health Care

Respiratory, complex rehab, custom orthotics/prosthetics, therapeutic shoes, ocular prostheses

### American Board for Certification in Orthotics & Prosthetics, Inc.

Respiratory, complex rehab, custom orthotics/prosthetics, therapeutic shoes, ocular prostheses



## Provider quality attestation (cont.)

### Board of Certification/Accreditation International

Respiratory, complex rehab, custom orthotics/prosthetics, therapeutic shoes, ocular prostheses

### Commission on Accreditation of Rehabilitation Facilities (CARF)

Respiratory, complex rehab, custom orthotics/prosthetics, therapeutic shoes, ocular prostheses

### Community Health Accreditation Program (CHAP)

Respiratory, complex rehab, Custom Orthotics/prosthetics, therapeutic shoes, ocular prostheses

### HealthCare Quality Association on Accreditation

Respiratory, complex rehab, custom orthotics/prosthetics, therapeutic shoes, ocular prostheses

## Provider quality attestation (cont.)

My Initials attest that the requesters **facility** is a Medicare-certified provider in good standing. Requesters **facility** is accredited by the following for services being requested. Provide copy of **facility** accreditation. Initials:

### National Association of Boards of Pharmacy

Respiratory, breast prosthetics, therapeutic shoes/inserts

### The Compliance Team, Inc.

Respiratory, complex rehab, custom orthotics/prosthetics, therapeutic shoes, ocular prostheses

### The Joint Commission

Respiratory, complex rehab, custom orthotics/prosthetics, therapeutic shoes, ocular prostheses

## Type of participation agreement requested

### Check all that apply:

UnitedHealthcare commercial plans

UnitedHealthcare® Medicare Advantage

UnitedHealthcare Community Plan (Medicaid)

State abbreviation

Medicaid number

Medicare number

### Existing network provider:

Current contract termination date

Current contract termination notice date

Current contracted fee schedule

## Services provided

### Identify the provider's top 3 specialties and annual UnitedHealthcare claim volume (in thousands) for those specialties

Bone growth	\$	Negative pressure wound therapy	\$
Breast pump	\$	Orthotics	\$
Complex rehab	\$	Ostomy	\$
Continuous passive motion (CPM)	\$	Pneumatic compression	\$
Diabetic shoes	\$	Prosthetics	\$
Diabetic testing	\$	Respiratory	\$



**Services provided (cont.)**

**Identify the provider's top 3 specialties and annual UnitedHealthcare claim volume (in thousands) for those specialties**

Durable medical equipment (DME) and supplies	\$	Respiratory vest	\$
Dynamic splinting	\$	Speech generating device	\$
Enteral	\$	Transcutaneous electrical nerve stimulation (TENS)	\$
Incontinence	\$	Urology	\$
Insulin therapy	\$	Other (specify)	\$

**Place of service address:**

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**Counties served:**

**Languages spoken:**

**Languages written:**

**Attestation**

**I attest that the provided in this document is true and correct.**

Signature:

Printed name:

Title:

Date signed:

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.

