UNIVERSITY OF UTAH HEALTH PLANS | Provider Relations & Contracting
801.587.2838 provider.relations@hsc.utah.edu

Introduction to Provider Networks & Provider Applicant Process

The University of Utah Health Plans (UUHP) contracts with physicians and other health care professionals and facilities to offer provider networks essential to the delivery of health care and services to our members. UUHP is committed to the "triple aim" of improving experience and quality of care, improving the health of populations, and reducing the per capita cost of care.

We recognize the importance of population health and payment reform and have developed extensive care management and value-based payment programs that improve health and align provider reimbursement with value and positive outcomes.

Provider applications to participate in any UUHP network are considered based on the following:

- UUHP business needs
- The credentialing process

  All providers must be approved through our credentialing process before they may participate in any network.

Business needs may include and are not limited to:

- Network adequacy requirements based on state and/or federal guidelines
- Network adequacy requirements based on the current or expected population of a given geographic area (usually defined by county or zip code)
- Network adequacy requirements based on provider type and/or specialty
- Network composition based on scope of services required by payer such as employer, health plan, union/trust, government entity, etc.
- Network performance requirements in terms of cost/utilization, quality measures, outcomes, access, and/or patient or physician satisfaction.
- Demographic needs including but not limited to languages spoken
- Existing, non-compensated, referral patterns with current network providers and/or UUHP members

Benefits of participating with a UUHP network include:

- Claim payments made to you directly on a weekly basis.
- Provider Relations representatives are available to help you and your staff.
- Inclusion in UUHP's on-line and printed provider directories made available to brokers, employers and members for the applicable products.
- Member benefits are designed to encourage use of network providers.
- Participation with U Link – an online tool to verify eligibility, check claims status, submit inquiries, etc.

For consideration, please fill out the following forms and return to UUHP via email, provider.relations@hsc.utah.edu, or fax, 801-281-6121.

For your convenience; the following forms may be filled out electronically.

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The University of Utah Health Plans offers the following plans and networks.

Please check the networks that you are interested in participating with:

☐ Healthy U: A Utah Medicaid Accountable Care Organization (ACO) plan and network available to eligible Medicaid members in the entire State of Utah.

☐ H.O.M.E.: A Coordinated Healthcare Model, in partnership with the University Neuropsychiatric Institute, to meet the medical and mental health needs of people with developmental disabilities.

☐ Healthy Premier: A statewide commercial network offered to employer groups for their employees.It is also available on the "Individual Marketplace Exchange".

☐ Healthy Preferred: A commercial, narrow, network available to employer groups, primarily along the Wasatch Front.

Completion of this application does not guarantee a contract or participation with the University of Utah Health Plans.

Please give a brief description of your services or scope of practice, in the space below:
(You may attach your marketing material.)

In lieu of Exhibit B you may submit a roster, if it contains the same information as requested in Exhibit B

Exhibit B

An electronic roster containing this information may be submitted in lieu of completing this form!

BUSINESS CONTACT INFORMATION			
Legal Name of Business: (As found on your W-9)		**Office / Clinic name:** (How you would like to be listed in our directory)	
Specialty(s):		Group Practice or Individual Practice:	
Office Manager:	Office Manager's or back Office Phone:	Office Manager's E-mail:	
Office or Clinic Street Address:			
City:		State:	ZIP code:
To receive our Electronic Provider Newsletter, please list recipient's email address:			
Group Tax ID:	Group NPI:	Group EDI:	
Credentialing Contact Name:	Credentialing Contact Phone:	Credentialing Contact E-mail:	
CLINIC / OFFICE LOCATION INFORMATION			
Primary Clinic / Office Name (If different from above):			
Clinic Address (If different from above):			
City: (If different from above):		State:	ZIP Code:
Receptionist or Appointment Telephone: (Phone number you want listed in our provider directories)		Front Desk Fax: Back Desk Fax:	
Billing Address & Location (If different from above):		Billing Contact Name:	
City:		State:	ZIP Code:
Billing Telephone:	Billing Fax:	Billing E-mail:	

Exhibit B

ADDITIONAL CLINIC / OFFICE LOCATION		
Additional Clinic / Office Name (If different from above):		
Clinic Address (If different from above):		
City: (If different from above):	State:	ZIP Code:
Receptionist Telephone:	Appointment Telephone: (If different than Receptionist)	Front Desk Fax:
		Back Desk Fax:
Billing Address & Location (If different from above):		Billing Contact Name:
City:	State:	ZIP Code:
Billing Telephone:	Billing Fax:	Billing E-mail:
ADDITIONAL CLINIC / OFFICE LOCATION		
Additional Clinic Name / Office (If different from above):		
Clinic Address (If different from above):		
City: (If different from above):	State:	ZIP Code:
Receptionist Telephone:	Appointment Telephone: (If different than Receptionist)	Front Desk Fax:
		Back Desk Fax:
Billing Address & Location (If different from above):		Billing Contact Name:
City:	State:	ZIP Code:
Billing Telephone:	Billing Fax:	Billing E-mail:

If you need to add more locations please copy page or submit an electronic roster with this information

Exhibit B

Individual Participating Provider Demographics

An electronic roster containing this information may be submitted in lieu of completing this form!

Provider # 1	
Name (Last, First, Middle, Degree):	Provider's Tax ID: (If different than group)
	Provider's Individual NPI:
Provider's Date of Birth (mm/dd/yy):	Provider's CAQH *(Council for Affordable Quality Healthcare)* Number:
Provider's Gender:	
Hospital Privileges (If applicable)	To self apply to CAQH, please see this site: www.caqh.org
	Provider's Specialty(s)
If provider has more than one location, specify the locations provider practices at, and specify primary practice location:	Languages spoken fluently, by provider, other than English:

Provider # 2	
Name (Last, First, Middle, Degree):	Provider's Tax ID: (If different than group)
	Provider's Individual NPI:
Provider's Date of Birth (mm/dd/yy):	Provider's CAQH *(Council for Affordable Quality Healthcare)* Number:
Provider's Gender:	
Hospital Privileges (If applicable)	To self apply to CAQH, please see this site: www.caqh.org
	Provider's Specialty(s)
If provider has more than one location, specify the locations provider practices at, and specify primary practice location:	Languages spoken fluently, by provider, other than English:

Exhibit B

Individual Participating Provider Demographics

An electronic roster containing this information may be submitted in lieu of completing this form!

Provider # 3	
Name (Last, First, Middle, Degree):	Provider's Tax ID: (If different than group)
	Provider's Individual NPI:
Provider's Date of Birth (mm/dd/yy):	Provider's CAQH *(Council for Affordable Quality Healthcare)* Number:
Provider's Gender:	
Hospital Privileges (If applicable)	To self apply to CAQH, please see this site: www.caqh.org
	Provider's Specialty(s)
If provider has more than one location, specify the locations provider practices at, and specify primary practice location:	Languages spoken fluently, by provider, other than English:

Provider # 4	
Name (Last, First, Middle, Degree):	Provider's Tax ID: (If different than group)
	Provider's Individual NPI:
Provider's Date of Birth (mm/dd/yy):	Provider's CAQH *(Council for Affordable Quality Healthcare)* Number:
Provider's Gender:	
Hospital Privileges (If applicable)	To self apply to CAQH, please see this site: www.caqh.org
	Provider's Specialty(s)
If provider has more than one location, specify the locations provider practices at, and specify primary practice location:	Languages spoken fluently, by provider, other than English:

Exhibit B

Individual Participating Provider Demographics

An electronic roster containing this information may be submitted in lieu of completing this form!

Provider # 5	
Name (Last, First, Middle, Degree):	Provider's Tax ID: (If different than group)
	Provider's Individual NPI:
Provider's Date of Birth (mm/dd/yy):	Provider's CAQH *(Council for Affordable Quality Healthcare)* Number:
Provider's Gender:	
Hospital Privileges (If applicable)	To self apply to CAQH, please see this site: www.caqh.org
	Provider's Specialty(s)
If provider has more than one location, specify the locations provider practices at, and specify primary practice location:	Languages spoken fluently, by provider, other than English:

Provider # 6	
Name (Last, First, Middle, Degree):	Provider's Tax ID: (If different than group)
	Provider's Individual NPI:
Provider's Date of Birth (mm/dd/yy):	Provider's CAQH *(Council for Affordable Quality Healthcare)* Number:
Provider's Gender:	
Hospital Privileges (If applicable)	To self apply to CAQH, please see this site: www.caqh.org
	Provider's Specialty(s)
If provider has more than one location, specify the locations provider practices at, and specify primary practice location:	Languages spoken fluently, by provider, other than English: