HEALTH PLANS
UNIVERSITY OF UTAH

Provider Networks & Provider Applicant Process

Provider applications to participate in any U of U Health Plan network are considered based on the following:

- 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 U of U Health Plans members

Benefits of participating with a U of U Health Plan 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 our 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 Link, our online tool to verify eligibility, check claims status, submit inquiries, etc.

For consideration in one or more of our networks, fill out the following forms and return via secure email to **ProviderContracting@hsc.utah.edu** or fax to **801-281-6121**.

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

University of Utah Health Plans Provider Networks

Indicate the networks with which you are interested in participating:

- ☐ Healthy U – A Utah Medicaid Accountable Care Organization (ACO) network available to eligible Medicaid members in the entire State of Utah.
- ☐ Healthy U Behavioral – A Medicaid behavioral and substance abuse network available to eligible Davis, Salt Lake, Summit, Utah, and Weber county residents.
- ☐ Healthy Premier – A provider network for employer groups in Utah and Southeastern Idaho. It is also available on the Utah Individual Marketplace Exchange.
- ☐ Healthy Preferred – A provider network for employer groups, primarily along the Wasatch Front. It is also available on the Individual Marketplace Exchange in the following counties: Davis, Salt Lake, Utah, and Weber. This network is intended to be a narrow provider panel. In most cases, the reimbursement is less than the Healthy Premier plan.
- ☐ Advantage U – Medicare Advantage product in Davis, Salt Lake, Tooele, Utah, and Weber counties. This plan will be available to our Medicare Advantage members effective January 1, 2021.

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

Briefly describe your services or scope of practice in the space below
(You may attach your marketing material.)

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Provider Application – Exhibit B

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

ORGANIZATION INFORMATION	
Legal Name of Organization/Parent Company: (Legal name listed with IRS)	
DBA Name of Organization: (If applicable)	
Organization Medicare # *(primary)*	**Organization Medicaid #** *(primary)*
Organization TIN *(primary)*	**Organization NPI** *(primary)*
Organization or Group's Specialty	**Organization licensed to operate in state?** ◯ Yes ◯ No **Is Organization Accredited?** ◯ Yes ◯ No
Ownership Type: ◯ Sole Proprietorship ◯ Corporate/LLC/Partnership ◯ City/County/State Owned ◯ Federally Owned	
Organization Location Address Street Address:	**Billing Address** *(if different than Primary Location Address)* Street Address:
Address Line 2:	Address Line 2:
City: State: Zip:	City: State: Zip:
Contact:	Billing Contact:
Email:	Billing Email:
Phone:	Billing Phone:

Primary Location	
Location Name:	**Billing Address** *(if different than Primary Location Address)*
Group TIN/NPI Number:	**Street Address**:
Street Address:	**Address Line 2**:
City: **State:** **Zip:**	**City**: **State**: **Zip**:
Location Phone: **Location Fax:**	**Billing Contact**:
Location Contact Name:	**Billing Email**:
Contact Email Address:	**Billing Phone**:

Is the location handicap accessible?	◯ Yes ◯ No	**Does the location provide any of the following?**	
Does the location provide any of the following?		**Pediatric Services**	◯ Yes ◯ No
Visual impairment accommodations	◯ Yes ◯ No	**Virtual Visits**	◯ Yes ◯ No
Language translation/interpretation services	◯ Yes ◯ No	**Mental Health Treatment**	◯ Yes ◯ No
Hearing impairment accommodations	◯ Yes ◯ No	**Substance Abuse Treatment**	◯ Yes ◯ No
Extended hours	◯ Yes ◯ No	**Please explain:** _____	
Does the location have age restrictions?	◯ Yes ◯ No	**Please explain:** _____	
Does the location have gender restrictions?	◯ Yes ◯ No	**Please explain:** _____	
Does the location have any other restrictions?	◯ Yes ◯ No	**Please explain:** _____	
Is domestic violence support available?	◯ Yes ◯ No	**Most recent Cultural Competency training date:** _____	

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LOCATION #2

Location Name:	**Billing Address** *(if different than Primary Location Address)*
Group TIN/NPI Number:	**Street Address**:
Street Address:	**Address Line 2**:
City: **State:** **Zip:**	**City**: **State**: **Zip**:
Location Phone: **Location Fax:**	**Billing Contact**:
Location Contact Name:	**Billing Email**:
Contact Email Address:	**Billing Phone**:

Is the location handicap accessible? ◯Yes ◯No

Does the location provide any of the following?

- **Visual impairment accommodations** ◯Yes ◯No
- **Language translation/interpretation services** ◯Yes ◯No
- **Hearing impairment accommodations** ◯Yes ◯No
- **Extended hours** ◯Yes ◯No

Does the location have age restrictions? ◯Yes ◯No **Please explain:** _____

Does the location have gender restrictions? ◯Yes ◯No **Please explain:** _____

Does the location have any other restrictions? ◯Yes ◯No **Please explain:** _____

Is domestic violence support available? ◯Yes ◯No

Does the location provide any of the following?

- **Pediatric Services** ◯Yes ◯No
- **Virtual Visits** ◯Yes ◯No
- **Mental Health Treatment** ◯Yes ◯No
- **Substance Abuse Treatment** ◯Yes ◯No

Please explain: _____

Most recent Cultural Competency training date:

LOCATION #3

Location Name:	**Billing Address** *(if different than Primary Location Address)*
Group TIN/NPI Number:	Street Address:
Street Address:	Address Line 2:
City: **State:** **Zip:**	City: State: Zip:
Location Phone: **Location Fax:**	Billing Contact:
Location Contact Name:	Billing Email:
Contact Email Address:	Billing Phone:

Is the location handicap accessible? ◯Yes ◯No

Does the location provide any of the following?

- **Visual impairment accommodations** ◯Yes ◯No
- **Language translation/interpretation services** ◯Yes ◯No
- **Hearing impairment accommodations** ◯Yes ◯No
- **Extended hours** ◯Yes ◯No

Does the location have age restrictions? ◯Yes ◯No **Please explain:** _____

Does the location have gender restrictions? ◯Yes ◯No **Please explain:** _____

Does the location have any other restrictions? ◯Yes ◯No **Please explain:** _____

Is domestic violence support available? ◯Yes ◯No

Does the location provide any of the following?

- **Pediatric Services** ◯Yes ◯No
- **Virtual Visits** ◯Yes ◯No
- **Mental Health Treatment** ◯Yes ◯No
- **Substance Abuse Treatment** ◯Yes ◯No

Please explain: _____

Most recent Cultural Competency training date:

Additional locations may be added by including all information on separate sheets.

Provider Information – Exhibit B (Continued)

- *Do not include Locum Tenens Provider in this application.*
- *You may submit Provider Information using your existing provider roster; however, it must contain all of the information requested in this form.*

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

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

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

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

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

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

Additional providers may be added by including all information on separate sheets.

Provider agrees University of Utah Health Plans may share provider application and related credentialing information with any group or entity that has delegated or contracted with U of U Health Plans to provide such activities on their behalf. Information cannot be shared for any reason except for provider directory/demographic and credentialing activities.

U of U Health Plans does not discriminate based on race, gender, nationality, age, sexual orientation, or the type of procedure or patient in whom the practitioner specializes.