HEALTH PLANS
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PROVIDER NETWORKS AND 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
- Eligibility to register for Provider Portal, our online tool to verify eligibility, check claims status, submit inquiries, and more

For consideration in one or more of our networks, fill out the following forms and return them **with a copy of your W-9** 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.

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UNIVERSITY OF UTAH HEALTH PLANS PROVIDER NETWORKS

Indicate the networks with which you are interested in participating. Click the box next to each network with which you'd like to participate. To deselect a check mark, click the box again. The check will be removed with your next mouse click anywhere in the document.

☐ **Healthy U** – A Utah Medicaid Accountable Care Organization (ACO) network available to eligible Medicaid members in the entire State of Utah. Healthy U also supports the Healthy Outcomes Medical Excellence (HOME) program, which provides medical and behavioral health services for members with developmental disabilities and mental illness.

☐ **CHIP** – A provider network, effective July 1, 2024, to support the **C**hildren's **H**ealth **I**nsurance **P**rogram, a state-sponsored medical and behavioral health insurance plan for children who do not have other insurance.

☐ **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 in Davis, Salt Lake, Utah, and Weber counties. This network is intended to be a narrow provider panel. In most cases, the reimbursement is less than the Healthy Premier plan.

Note: The Huntsman Mental Health Institute (HMHI) Behavioral Health Network (BHN) is contracted through Huntsman Mental Health Institute. For information or contracting opportunities, email **Jessie.Konate@hsc.utah.edu** or call **801-646-7363**.

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

Completely describe your services or scope of practice in the space below. Please also attach any marketing materials when you submit your application.

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PROVIDER APPLICATION – EXHIBIT B

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

PRACTICE INFORMATION	
Legal Name of Practice/Parent Company (*Legal name listed with IRS; W-9 must be attached*)	
DBA Name of Practice (*If applicable*)	
Practice Medicaid # (*required if applying for Medicaid*)	
Practice TIN (*primary*)	**Practice NPI**
Practice licensed to operate in state? Yes ☐ No ☐	**Is Practice Accredited?** Yes ☐ No ☐
Practice or Group's Specialty	
Does Practice submit claims electronically? Yes ☐ No ☐ (*If no, provide explanation*)	

Contracting Contact Information	Credentialing Contact Information
Street Address	Street Address
Address Line 2	Address Line 2
City State Zip	City State Zip
Contact	Contact
Email	Email
Phone	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
Does the location provide any of the following?	
Visual impairment accommodations Yes ☐ No ☐	Pediatric Services Yes ☐ No ☐
Language translation/interpretation Yes ☐ No ☐	Mental Health Treatment Yes ☐ No ☐
Hearing impairment accommodations Yes ☐ No ☐	Substance Abuse Treatment Yes ☐ No ☐
Extended hours Yes ☐ No ☐ Hours	Virtual Visits Yes ☐ No ☐ % of Visits
Does location have age restrictions? Yes ☐ No ☐ (*Please explain*)	Does location have gender restrictions? Yes ☐ No ☐ (*Please explain*)
Does location have any other restrictions? Yes ☐ No ☐ (*Please explain*)	
Is location handicap accessible? Yes ☐ No ☐ (*If not, please explain*)	Is location ADA compliant? Yes ☐ No ☐ (*If not, please explain*)
Is domestic violence support available? Yes ☐ No ☐	Last 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
Does the location provide any of the following?	
Visual impairment accommodations Yes ☐ No ☐	Pediatric Services Yes ☐ No ☐
Language translation/interpretation Yes ☐ No ☐	Mental Health Treatment Yes ☐ No ☐
Hearing impairment accommodations Yes ☐ No ☐	Substance Abuse Treatment Yes ☐ No ☐
Extended hours Yes ☐ No ☐ Hours	Virtual Visits Yes ☐ No ☐ % of Visits
Does location have age restrictions? Yes ☐ No ☐ (*Please explain*)	Does location have gender restrictions? Yes ☐ No ☐ (*Please explain*)
Does location have any other restrictions? Yes ☐ No ☐ (*Please explain*)	
Is location handicap accessible? Yes ☐ No ☐ (*If not, please explain*)	Is location ADA compliant? Yes ☐ No ☐ (*If not, please explain*)
Is domestic violence support available? Yes ☐ No ☐	Last 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
Does the location provide any of the following?	
Visual impairment accommodations Yes ☐ No ☐	Pediatric Services Yes ☐ No ☐
Language translation/interpretation Yes ☐ No ☐	Mental Health Treatment Yes ☐ No ☐
Hearing impairment accommodations Yes ☐ No ☐	Substance Abuse Treatment Yes ☐ No ☐
Extended hours Yes ☐ No ☐ Hours	Virtual Visits Yes ☐ No ☐ % of Visits
Does location have age restrictions? Yes ☐ No ☐ (*Please explain*)	Does location have gender restrictions? Yes ☐ No ☐ (*Please explain*)
Does location have any other restrictions? Yes ☐ No ☐ (*Please explain*)	
Is location handicap accessible? Yes ☐ No ☐ (*If not, please explain*)	Is location ADA compliant? Yes ☐ No ☐ (*If not, please explain*)
Is domestic violence support available? Yes ☐ No ☐	Last Cultural Competency training date

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

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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 Specialty(ies)**
Provider's Date of Birth (*mm/dd/yyyy*)	**Provider's Individual NPI**
Provider's Gender Male ☐ Female ☐	**Provider's CAQH Number** (Council for Affordable Quality Healthcare) To self-apply to CAQH, visit caqh.org
Languages other than English spoken fluently by provider	
Hospital Admitting Privileges or Admit Plan	**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 Specialty(ies)**
Provider's Date of Birth (*mm/dd/yyyy*)	**Provider's Individual NPI**
Provider's Gender Male ☐ Female ☐	**Provider's CAQH Number** (Council for Affordable Quality Healthcare) To self-apply to CAQH, visit caqh.org
Languages other than English spoken fluently by provider	
Hospital Admitting Privileges or Admit Plan	**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 Specialty(ies)**
Provider's Date of Birth (*mm/dd/yyyy*)	**Provider's Individual NPI**
Provider's Gender Male ☐ Female ☐	**Provider's CAQH Number** (Council for Affordable Quality Healthcare) To self-apply to CAQH, visit caqh.org
Languages other than English spoken fluently by provider	
Hospital Admitting Privileges or Admit Plan	**Areas of Interest**
If provider has more than one location, specify the primary location and additional practice location(s)	

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Provider #4	
Name (*Last, First, Middle, Degree*)	**Provider's Specialty(ies)**
Provider's Date of Birth (*mm/dd/yyyy*)	**Provider's Individual NPI**
Provider's Gender Male ☐ Female ☐	**Provider's CAQH Number** (Council for Affordable Quality Healthcare) To self-apply to CAQH, visit caqh.org
Languages other than English spoken fluently by provider	
Hospital Admitting Privileges or Admit Plan	**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 Specialty(ies)**
Provider's Date of Birth (*mm/dd/yyyy*)	**Provider's Individual NPI**
Provider's Gender Male ☐ Female ☐	**Provider's CAQH Number** (Council for Affordable Quality Healthcare) To self-apply to CAQH, visit caqh.org
Languages other than English spoken fluently by provider	
Hospital Admitting Privileges or Admit Plan	**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 Specialty(ies)**
Provider's Date of Birth (*mm/dd/yyyy*)	**Provider's Individual NPI**
Provider's Gender Male ☐ Female ☐	**Provider's CAQH Number** (Council for Affordable Quality Healthcare) To self-apply to CAQH, visit caqh.org
Languages other than English spoken fluently by provider	
Hospital Admitting Privileges or Admit Plan	**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.