HEALTH PLAN OF NEVADA
A UnitedHealthcare Company

PROVIDER QUESTIONNAIRE FORM
FOR ABA PROVIDERS

GROUP / FACILITY IRS NAME (if applicable)

DBA NAME

CONTRACTING SPECIALTY

TAX ID #

NATIONAL PROVIDER IDENTIFICATION NUMBER (NPI)

GROUP CONTACT/ADMINISTRATOR NAME E-MAIL PHONE

BILILNG INFORMATION:

ADDRESS STE. # CITY/STATE/ZIP
(If you have additional billing locations, please list on a separate page)

PHONE # FAX #

PRIMARY LOCATION:

PRACTICE NAME PHONE # FAX #

ADDRESS STE. #

CITY STATE ZIP OFFICE HOURS

ADDITIONAL LOCATION (if applicable)

PRACTICE NAME PHONE # FAX #

ADDRESS STE. #

CITY STATE ZIP OFFICE HOURS

ADDITIONAL LOCATION (if applicable)

PRACTICE NAME | PHONE # | FAX #

ADDRESS | STE. #

CITY | STATE | ZIP | OFFICE HOURS

CREDENTIALING CONTACT INFORMATION:

NAME | E-MAIL

PHONE # | FAX #

CREDENTIALING ADDRESS (IF DIFFERENT THAN PRIMARY ADDRESS LISTED ABOVE).

INDIVIDUAL PROVIDER INFORMATION

PLEASE ATTACH PHYSICIAN ROSTER AND INCLUDE THE FOLLOWING DEMOGRAPHIC INFORMATION FOR EACH INDIVIDUAL PROVIDER.

- PROVIDER LAST NAME
- PROVIDER FIRST NAME
- PROVIDER MIDDLE INITIAL
- TITLE
- SPECIALTY
- LANGUAGES SPOKEN
- MEDICAID ID #
- NATIONAL PROVIDER IDENTIFICATION # (NPI)
- PROVIDER LOCATIONS INCLUDING:
    - ADDRESS (list all applicable address)
    - STE. # (if applicable)
    - CITY
    - STATE
    - ZIP
    - TELEPHONE #
    - FAX #

OTHER REQUIRED DOCUMENTS:

- COPY OF CURRENT W-9
- COPY OF SS4 OR 147C LETTER FROM THE IRS (confirmation letter from the IRS listing your Tax ID #)

THANK YOU!
Please return via fax to (702) 266-8809