UnitedHealthcare Community Plan

REQUEST FOR PARTICIPATION FORM

Please fax form to 248-331-4473
Attn: Provider Service Department

Provider is interested in participating as: *(Please choose one)* ☐ **PCP** ☐ **Specialist** ☐ **Allied Health** **Facility** **Ancillary**			
Provider Name		**License State and Number**	
Specialty		**DEA Number**	
Board Certified?	☐ **Yes** ☐ **No**	**NPI Number**	

Tax Identification Number (TIN)		
If applicable, please list all providers under the same TIN		

Name of Office			
Address			
City		**State**	
Zip		**County**	
Telephone		**Fax**	
Contact Person		**Title**	
E-Mail Address		**Website**	