UOP, LLC

Please Print Clearly or Type. Highlighted Fields Must Be Answered

Last: ____________ **First:** ____________ **MI:** ____ **Title:** ____ ____**PCP** ____ **SCP** (Check One)

Gender: ___M / ___F (Check One) **DOB:** ____________ **SSN:** ____________

Ethnicity: ____________ **Language(s) Spoken:** ____________

Primary Practice Name: ____________ **Start Date:** ____________

Tax ID: ____________ **Group NPI:** ____________ (Required)

Address: ____________ **City:** ____________ **State:** ____ **Zip Code:** ____

Hours: Mon ______ Tues ______ Wed ______ Thurs ______ Fri ______ Sat ______

E-Mail Address: ____________ **Office Manager:** ____________

Office Phone: ____________ **Office Fax:** ____________ **Beeper:** ____________

Secondary Practice Name: ____________ **Start Date:** ____________

Tax ID: ____________ **Group NPI:** ____________

Address: ____________ **City:** ____________ **State:** ____ **Zip Code:** ____

Hours: Mon ______ Tues ______ Wed ______ Thurs ______ Fri ______ Sat ______

E-Mail Address: ____________ **Office Manager:** ____________

Office Phone: ____________ **Office Fax:** ____________ **Beeper:** ____________

Home Address: ____________ **Phone Number:** ____________

Specialty: ____________ **Hospital Privileges:** ____________

Certified: ____Yes / ____No (Check One) **Eligible:** ____ ____________

Board Certification Date: ______ ____________

Recertification Date: ______ ____________

Board Certification Expiration: ______ ____________

DEA Number: ____________ **Expiration Date:** ______

MI Medical License: ____________ **Expiration Date:** ______

MI Controlled Substance: ____________ **Expiration Date:** ______

Other State License(s): ____________ **Expiration Date:** ______

CAQH Number: ____________

NPI Number: ____________

Tax ID: ____________

ECFMG: ____________

Medicaid Number: ____________

Medicare Number: ____________

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UNITED OUTSTANDING PHYSICIANS
OUR PATIENTS COME FIRST

UOP, LLC

PLEASE ATTACH A 5 YEAR WORK HISTORY ON AN ADDITIONAL SHEET
Please Print Clearly or Type Answers. Highlighted Fields Must Be Answered.

Program	Institution	Department	Degree	Start Date – End Date
University				/ / To / / M D Yr M D Yr
Internship				/ / To / / M D Yr M D Yr
Residency				/ / To / / M D Yr M D Yr
Fellowship				/ / To / / M D Yr M D Yr

References: (List 3 References)

Name: ______________________

Address: ______________________ **City:** __________ **State:** ______ **Zip Code:** ______

Phone: ______________________ **Fax:** ______________________

Name: ______________________

Address: ______________________ **City:** __________ **State:** ______ **Zip Code:** ______

Phone: ______________________ **Fax:** ______________________

Name: ______________________

Address: ______________________ **City:** __________ **State:** ______ **Zip Code:** ______

Phone: ______________________ **Fax:** ______________________

Current Malpractice Insurance Company (All Questions Below Must Be Answered):

______________________________________ **Policy #:** __________

Effective Date: ______________ **Retro Date:** __________ **Exp. Date:** __________

Amount Per Incident: __________ **Aggregate Amount:** __________

Malpractice Insurance Coverage For Past 5 Years: ______________________

Previous Malpractice Insurance Company: ______________________

Effective Date: __________ **Retro Date:** __________ **Exp. Date:** __________

Amount Per Incident: ______________ **Aggregate Amount:** ______________

UOP, LLC

CHECKLIST FOR EXECUTED UOP CONTRACTS

Physician Name ________________________________

Specialty _____________________________________

Physician Signature: **Date:**

Please check the box indicating which UOP contracts Physician is interested in participating with through UOP.
(UOP Membership does not guarantee participation in the plans)

- ☐ BCN (Blue Care Network IH-12 - UOP, LLC- Fee For Service)
  - BCNA (Blue Care Network Medicare Advantage)
- ☐ BCN (IH-08 Best of Health)
  ****For PCP please choose only one BCN Group****
- ☐ Blue Cross Complete (BCC) (HMO Medicaid)
- ☐ Health Alliance Plan HMO
- ☐ Health Alliance Plan Senior Plus HMO
- ☐ Health Alliance Plan PHP (Medicare PPO/POS/EPA/EPO)
- ☐ Molina Medicaid
- ☐ Molina Medicare Options Plus
- ☐ Molina Marketplace
- ☐ Priority Health (includes HMO, PPO)
- ☐ Priority Health Medicare Advantage
- ☐ UOP ACO- Medicare Shared Savings Program (MSSP)

Please list below the Health Plan and IPA group you currently participate with.

Molina Health Plan ________________________________

Priority Health ________________________________

Health Alliance Plan ________________________________

Blue Care Network ________________________________

Blue Cross Complete ________________________________