UOP, LLC

Please Print Clearly or Type. **Highlighted Fields Must Be Answered**

Last: ______ **First:** ______ **MI:** ______ **Title:** ______ **PCP / SCP** (Circle One)

Gender: M / F (Circle 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 (Circle 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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NITED UTSTANDING HYSICIANS

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: ______________________ E-Mail: ______________________

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

Phone: ______________________ Fax: ______________________

Name: ______________________ E-Mail: ______________________

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

Phone: ______________________ Fax: ______________________

Name: ______________________ E-Mail: ______________________

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: __________

Please Include Malpractice Insurance Coverage For Past 5 Years: ______________________

Previous Malpractice Insurance Company: ______________________

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

Amount Per Incident: ______________ Aggregate Amount: ______________

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 (Capitation)
  ****For PCPs only****
- ☐ Health Alliance Plan (HAP) HMO
- ☐ Health Alliance Plan Senior Plus HMO
- ☐ Health Alliance Plan PHP (Medicare PPO/POS/EPA/EPO)
- ☐ HAP Empowered (HAP Midwest Health Plan)
- ☐ Henry Ford Preferred Network
- ☐ Molina Medicaid
- ☐ Molina Medicare Options Plus
- ☐ Priority Health (includes HMO, PPO)
- ☐ Priority Health Medicare Advantage
- ☐ Priority Choice Medicaid
- ☐ Priority Health – Corewell Health Narrow Network
- ☐ UOP ACO- Medicare Shared Savings Program (MSSP)
  ****For PCPs only****

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

Molina Health Plan ______________________________

Priority Health ______________________________

Health Alliance Plan ______________________________

Blue Care Network ______________________________