HEALTH PLAN OF NEVADA
A UnitedHealthcare Company

SIERRA HEALTH AND LIFE
A UnitedHealthcare Company

PROVIDER ADD REQUEST

This form must be completed in full before the Credentialing Department can start the credentialing process on the following provider. The provider must hold a valid license in the State of their primary location.

Provider Name: _____ _____ _____
Last First Middle

Title: ☐ MD ☐ DO ☐ DC ☐ DPM ☐ CRNA ☐ PAC ☐ DMD ☐ DDS
☐ APN – Preceptor:_____ ☐ Other (specify):_____

Date of Birth: _____ **Gender:** ☐ Male ☐ Female

Social Security #: _____ **CAQH #:** _____

Billing Tax ID #: _____ **Individual NPI #:** _____

Effective Date with Group: _____ **Medicaid #:** _____

Group Name: _____

Group NPI #: _____

Primary Specialty: _____ **Additional Specialty:** _____

Line of Business to Add: ☐ HPN ☐ MEDICAID ☐ SHL ☐ SHO ☐ MAPP ☐ SAW ☐ NNHN

Primary Address: _____ _____ _____ _____
Street City State Zip

Primary Phone: _____

Additional sites to Primary Address: _____ _____ _____ _____
Street City State Zip

Additional Phone: _____

Additional sites to Primary Address: _____ _____ _____ _____
Street City State Zip

Additional Phone: _____

Credentialing Contact: _____ **Email:** _____

Phone: _____ **Fax:** _____

Mailing Address for Credentialing Application: _____