# UOP, LLC



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

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

**Gender:** ___**M** / ___**F** **DOB:** _____ **SSN:** _____
**(Check One)**
**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** **Eligible:** ___ _____
**(Check One)**
**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:** _____

# 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
- ☐ 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 _____