HEALTH PLAN OF NEVADA
A UnitedHealthcare Company

SIERRA HEALTH AND LIFE
A UnitedHealthcare Company

PROVIDER ADD REQUEST

Before Health Plan of Nevada and Sierra Health and Life can add the following provider to your group, the form must be completed in full. The provider must hold a valid license in the State of their primary location. (Please write legibly.)

➢ **New Provider Information**

Provider Name _____
Last Name First Middle

Title *(please check appropriate box)* o **MD** o **DO** o **DC** o **DPM** o **CRNA** o **DMD** o **DDS** o **Other** _____

o **PAC** o **APN** -- **Preceptor's Name** _____

Date of birth: _____ **NPI #:** _____

Billing Tax ID Number: _____ **Medicaid #:** _____

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

CAQH: _____ **Language(s) spoken #:** _____

➢ **Group/Practice Information**

Primary Group/Practice _____
Name of Group/Practice

Primary Specialty _____ **Additional Specialty** _____

Line(s) of business *(please check all that apply)* ☐ **HPN** ☐ **Medicaid** ☐ **SHL** ☐ **SHO** ☐ **SAW** ☐ **NNHN**

Primary Address _____
Street Suite City State Zip Phone

Office Hours Mon:_____ Tues:_____ Wed: _____ Thurs: _____ Fri: _____

Sat:_____ Sun: _____

Additional Site Location _____
Street Suite City State Zip Phone

Office Hours Mon:_____ Tues:_____ Wed: _____ Thurs: _____ Fri: _____

Sat:_____ Sun: _____

Additional Site Location _____
Street Suite City State Zip Phone

Office Hours Mon:_____ Tues:_____ Wed: _____ Thurs: _____ Fri: _____

Sat:_____ Sun: _____

➢ **Credentialing Information**

Credentialing Contact (please print): _____ E-mail: _____

Mailing Address for Credentialing Application (if different from primary address)

_____
Street Suite City State Zip Phone

➢ **Hospital Admit Plan**

Does Provider have hospital privileges? ☐ Yes ☐ No ☐ Not applicable

If yes, please list facilities: _____

Provider will only be rendering outpatient services: ☐ Yes ☐ No

If there is an emergency in your office, what is your admit plan?

☐ Call 911 ☐ Refer to closest Emergency Room for treatment. (List nearest facility) _____

☐ I am in the process of obtaining privileges. During the interim, the following provider will admit for me: _____

➢ **Outpatient Surgery Plan***

Does Provider have Ambulatory Surgery Center (ASC) privileges? ☐ Yes ☐ No ☐ Provider does not perform surgery

If yes, please list ASCs: _____

***Providers who perform surgeries on an outpatient basis are required to have privileges at a plan-contracted Ambulatory Surgery Center**

If the information submitted on this application is false, inaccurate, inappropriate or incomplete, the application will be withdrawn or will not be considered for enrollment in the network

THANK YOU!

Please return via fax to (702) 242-7853
or email to
NVSierraCred@sierrahealth.com