UNITEDHEALTHCARE
DOULA INFORMATION REQUEST

INSTRUCTIONS: Please complete this information request form in full and return with all requested documents. Use N/A to answer questions not applicable to your group. Statements left blank may delay the contracting process.

I. DOULA GROUP INFORMATION: Date: _____

1. Group/Individual Name: _____

2. Address: _____

   City: _____ State: _____ Zip: _____

   Phone Number: _____ Fax Number: _____

3. Group NPI: _____

4. Tax ID#: _____
   (Attach a completed IRS W-9 Form)

5. County(ies) served: _____

6. Is the above address used for payment and correspondence? ____Yes ____ No
   If no, please include the address used for those purposes:

   _____

   _____

8. Name/Title of Group Contact: _____

9. E-Mail Address: _____

10. Individual Provider Roster:

Provider Name	Provider NPI	Provider Registered in CHAMPS? (Y/N)

Please complete the form and return with your W-9 to Nicole O'Brien - nicole.obrien@uhc.com