%UCare

FACILITY LOCATION ADD FORM

Below is a grid that outlines which fields are required in order to submit the Facility Location Add Form and which fields are optional. Please be sure to complete all the required fields. Please allow **60 days** from the date submitted for the form to be processed.

If you have any questions, please call UCare's Provider Assistance Center at 612-676-3300 or toll free at 1-888-531-1493.

Required	Sections	Fields
Fields	Are you a contracted provider?	Yes or No
	Contact Information	Completed By
		• Title
		Phone Number
		Contact Email
	Main Facility Information	Facility Name
		Facility Physical Address
		City, State, Zip Code
		Phone Number
		Tax ID Number
	New Location Information	Effective Date of New Location
		New Facility Name
		 New Facility Physical Address
		City, State, Zip Code
		Phone Number
		Tax ID Number
		Specialty
	Practitioner Demographic Information	Last Name
		First Name
		Specialty
		• NPI/UMPI
		Practitioner Effective Date
	W9	All required Fields
	Signature	Type Full Name

Optional	Sections	Fields
Fields	Contact Information	Fax Number
		Name of Contract Manager and their
If available,		contact information
please provide.		
	Billing/Payment Information (if different	Facility Name
	from the new location address)	Facility Address
		City, State, Zip Code
		Phone Number
		Fax Number
		Tax ID Number

Please also select and/or complete the following fields on the form:

- Is your new location considered a primary care clinic?
- Hospital Privileges (where do you admit patients to)?
- Does your location have special restrictions? (Check all that applies and/or fill in the box)
- Does your facility offer languages other than English?
- Office Hours
- Urgent Care Hours (if available)