Site / Location Add Form

- A separate Site/Location Add Form must be completed for each new location.
- Each submission MUST include a completed W-9 form.
- For services with provider-specific rate methodologies (CAH, FQHC, RHC, ACT, CCBHC, CRT, IRMHS, IRTS, PRTF, RCS) please include a copy of the rate letter specific to the new site/location.
- All required facility and/or practitioner level credentialing must be completed, prior to request being processed--UCare® - Who Requires Credentialing
- For contracted providers only, all locations and practitioners must be actively enrolled with the state as a Minnesota Health Care Programs provider within 120 days of form submission.
- **The Site/Location Add Form should not be used to communicate Ownership changes, Tax ID, and/or Legal Name Changes. A "Site/Location Change Form" should be used for those update types.**

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

Which best describes your relationship with UCare. **CONTRACTED** ☐ **NON-CONTRACTED** ☐

MAIN LOCATION INFORMATION:	
Primary Location Legal Name:	**Primary NPI or Primary UMPI**:
Primary DBA/Site Name:	**Primary FEIN/TIN:**
Primary Physical Address:	**Primary Fax Number:**
Primary Phone Number:	

If a box is not relevant, please leave it blank.

NEW LOCATION INFORMATION:	
Legal Name:	**Effective Date of Location:**
DBA/Site Name:	**Facility Type:** ☐ Acupuncture ☐ Acute Care Hospital ☐ Ambulatory Surgery Center ☐ Audiology ☐ Birthing Center ☐ Community First Services & Supports/Personal Care Assistant ☐ Critical Access Hospital ☐ Dialysis ☐ Doula ☐ Durable Medical Equipment (DME) ☐ EIDBI ☐ EW ☐ Eyewear ☐ FQHC – Federally Qualified Health Center ☐ Home Health Care ☐ Home Infusion Therapy
Marketing Name:	

	☐ Hospice ☐ Interpreter ☐ Mental Health ☐ Orthotics/Prosthetics ☐ Professional Services ☐ RHC - Rural Health Clinic ☐ Specialty Care Clinic ☐ Transportation ☐ Other: **Services Provided:** ☐ ACT ☐ CCBHC ☐ FQHC ☐ IRTS ☐ RCS ☐ Other: ☐ HSS ☐ LTACH – Long Term Acute Care Hospital ☐ Optometry ☐ Primary Care ☐ PT/OT/ST ☐ SNF – Skilled Nursing Facility ☐ Substance Use Disorder ☐ Virtual Clinic ☐ CAH ☐ CRT ☐ IRMHS ☐ PRTF ☐ RHC
	Are you currently contracted with UCare for the types of services being provided at the new location? Yes: ☐ No: ☐
Physical Address (Address where member will receive services):	
Phone Number:	**Facility NPI or Facility UMPI:**
Fax Number:	**Facility FEIN/TIN:**
Facility Taxonomy:	**Medicare Number:**

Billing/Remit/EOP Name:	**Check/Pay to Name:**
Billing/Remit/EOP FEIN/TIN if different than facility FEIN/TIN:	**Check/Pay to FEIN/TIN if different:**
Billing/Remit/EOP NPI/UMPI:	**Check/Pay to NPI/UMPI**:
Billing/Remit/EOP Address (Address where remits and payments will be sent):	

The Billing/Remit/EOP information above applies to all locations listed under this FEIN/TIN

Yes: ☐ No: ☐

Contractual Mailing Address (For contracted providers, address where contractual documents will be sent):
Correspondence Address (Address where correspondence will be sent):

LOCATION CONTACT PERSON:	
Contact Name:	
Contact Phone Number:	**Contact Fax Number:**
Contact Email:	

Additional Information
Primary Care Clinic? Yes ☐ No ☐
If yes, which Primary Care Services are provided:
Are you accepting New Patients? Yes ☐ No ☐
Please list specific location restrictions, if any:
Please list any languages spoken by your practice:
Display Location in Directory: Yes: ☐ No: ☐
Hospital Privileges (where do you admit patients to)?

Please enter the days and times services are available at this location:

Day of the week	Opening Time	Closing Time
Monday		
Tuesday		
Wednesday		
Thursday		
Friday		
Saturday		
Sunday		

INDIVIDUAL PRACTITIONER INFORMATION: (Most facility adds must have at least one individual associated with the location).
Individual Provider/Practitioner Name:
Effective Date:
Specialty:
License Type:
Individual NPI/UMPI:

If more than one practitioner will be rendering services at this location, please complete and return the FAF Practitioner Template spreadsheet, rather than completing the section above.

Comments/Additional Information:

- **Please email completed forms and all required and applicable attachments (W9 and FAF Practitioner Template) to *demographicupdates@ucare.org*.**
- **Please include the Provider's Legal Name and type of change requested in the subject line of the email.**
- **UCare recommends keeping a copy of your original email on file for your records.**