people powered health plans

UCare Provider NDA Attestation

Email completed form, "un-signed" to ucareprcprojects@ucare.org. Incomplete forms will be returned without processing. For status checks and/or questions, please contact UCare' s Provider Assistance Center at: 612-676-3300 or toll free at 1-888-531-1493. Forms will be sent for signature through DocuSign for Owner/Authorized signer to sign, within 5 business days of submission.

By signing this form, you attest that you have a contractual agreement with the intermediary listed below & that UCare may provide information to this intermediary for the levels of access granted below. Any subcontracting, delegation, or assignment by Provider shall not relieve Provider of its obligations and Provider agrees that it shall be responsible for the actions or failures to act of all such parties as if an act or omission of Provider.

Type of Intermediary: check only the ones that are applicable:

☐ Full-Service Administrator (includes Contract Negotiations)

☐ Partial Service Administrator (does not include Contract Negotiations)

☐ Pharmaceutical Company

☐ Pharmaceutical Assistance Program

Please indicate the level of access granted: check all that apply:

☐ Appeals/Disputes	☐ Contracting/Fee Schedule	☐ Provider Demographic changes
☐ Banking/EFT/ERA/Remittance	☐ Credentialing	☐ Member Authorization
☐ Claims/Billing	☐ Financial Reporting	☐ Member Eligibility

☐ **Check here to add a new intermediary**	
Third Party Organization Name:	
Address (Street, City, State, Zip):	
Phone Number:	TIN:
Fax Number:	Email:
Effective Date:	

☐ **Check here to term an intermediary on file with us**	
Third Party Organization Name:	
Address (Street, City, State, Zip):	
Phone Number:	TIN:
Fax Number:	Email:
Term Date:	
☐ **Check here to update intermediary information on file with us**	
Third Party Organization Name Changed To:	
Change Address (Street, City, State, Zip) To:	
Change Phone Number To:	Change TIN To:
Change Fax Number To:	Change Email To:
Effective Date of Change:	

Provider Attestation Statement: "*I certify that the information on this form is true and correct. I will notify UCare of any changes or termination of this agreement.*" Owner or individual with signing authority must sign and date on the last field of this form.

Facility Legal Entity Name: (Clinic or group name goes here)	
Tax ID #:	NPI#:
Provider Owner Name (Please Print):	Owners Phone#:
If Owner is not signing, PRINT the name of the individual with signing authority here, otherwise leave this field blank:	Email:
SIGNATURE OF Owner or Individual with signing authority: (This is not the third-party signature; this is owner or authorized signing party)	Date: