UnitedHealthcare

Provider Information Form

Please complete the fields below if you intend to provide services to UnitedHealthcare members enrolled in the Kansas WORK Program.

Provider Name:		Contact Name (if applicable):	
Address	City:	State:	Zip Code
Phone Number:	Fax Number:	Email Address:	Tax ID/EIN:

Indicate whether you are:

☐ Agency, Organization or Company, OR

☐ Independent Contractor – If so, list Date of Birth:* ___/___/_____

*Individuals providing services to WORK participants must be at least 16 years of age.

If you indicated "Agency, Organization or Company", are you a Non-Profit?

☐ Yes

☐ No

If you answered "Yes" to Non-Profit above, please send proof of Non-Profit to:

Attn: KS WORK UHC
Public Partnerships LLC
One Cabot Road, Suite 102
Medford, MA 02155

If you answered "No", please complete the W-9 form provided in this packet.

REMINDER: Workers compensation is a required insurance plan provided by employers to pay employee benefits for job related injuries, disability, or death. The current workers compensation law (K.S.A. 44-505) covers all Kansas employers except for those in certain agricultural areas or those with a gross annual payroll of less than $20,000. As an employer, you are required to file an injury report within 28 days of learning of an employee's injury or death, and you must also provide written information to the employee with available benefits, a contact for workers compensation claims and the process.