Provider Demographic Form

Please fax your completed form to (844) 558-8451 or email it to visionnominations@uhc.com.

Reason for completing this form:

- ☐ New provider
- ☐ New location
- ☐ Change in ownership
- ☐ Changes to demographic information
- ☐ Change in billing address (only complete Section D below)

Section A – Provider Information

Please add additional sheets or a roster, if needed:

Name (First, Middle initial, Last):	
Email address:	
Degree:	Gender:
Date of birth:	Social Security Number:
CAQH #:	NPI #:
License (State & #):	Medicaid License (State & #):
Languages spoken:	

Name (First, Middle initial, Last):	
Email address:	
Degree:	Gender:
Date of birth:	Social Security Number:
CAQH #:	NPI #:
License (State & #):	Medicaid License (State & #):
Languages spoken:	

Section B – Service Location

Please add additional sheets or a roster, if needed:

Address line 1:		
Address line 2:		
City:	State:	Zip:
Phone:	Fax:	
Email:	Website:	
Staff languages spoken:		

Group NPI (NPI claims will be filed with):
Pennsylvania providers only:
Provider PA Promise ID address segment (4-digit #):
Billing Medicaid ID address segment (4-digit #):

Days and hours of operation						
Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

Select all applicable boxes relating to this location:

Services	Patients	Facility Description
☐ Exams ☐ Frames and glasses ☐ Contacts ☐ Mobile services ☐ Telemedicine ☐ Medically necessary contacts ☐ Keratoconus	☐ Accepting new patients ☐ Accepting existing patients ☐ Accepting children	☐ Medicaid ☐ Medicare ☐ Teaching facility ☐ Independent office ☐ Retail chain (please list chain): ☐ Affiliation membership (please list all that apply):

Minimum age accepted:	Maximum age accepted:

Handicap accessibility:	
☐ Parking: Handicap parking spaces are available	Enter the number of available handicap parking spaces:
☐ Exterior building: Accessible ramps, handicap access exterior entry doors, etc.	
☐ Interior building: Wide-entry hallways, elevators, handicap access interior doors, etc.	
☐ Restrooms: grab bars, wide-entry stalls, handicap-access sinks, etc.	
☐ Exam rooms/medical equipment: Handicap accessible exam rooms, adjustable exam tables and chairs, scales, other medical equipment, etc.	

Section C – Taxpayer/DBA Information (as registered with the IRS)

Please add additional sheets or a roster, if needed:

Name (line 1 of W-9):	
Business Name (line 2 of W-9):	
Federal Tax ID #:	
Is your group considered a Federally Qualified Health Center ("FQHC")? ☐ Yes ☐ No	
Is your group considered a Rural Health Clinic ("RHC")? ☐ Yes ☐ No	
Participating Medicaid state:	Billing Medicaid ID #: Billing
Participating Medicaid state:	Medicaid ID #:
Participating Medicaid state:	Billing Medicaid ID #:

Section D – Billing Address

Address where you want payments sent for this location. Does not have to be the W-9 address.
P.O. Boxes are not allowed for billing address.

Address line 1:		
Address line 2:		
City:	State:	Zip:
Phone:	Fax:	
Email address for billing communications:		

Complete if this is a new ownership of an existing UnitedHealthcare | March Vision care practice

Effective date of new ownership:	Termination date of original ownership:
New TIN:	Original TIN:

By entering my name and date below, I attest to UnitedHealthcare I March Vision Care that the information contained in the attached application is true and complete to the best of my knowledge. I agree to inform UnitedHealthcare I March Vision Care promptly if any material change in such information occurs, whether before or after entering into an agreement with UnitedHealthcare I March Vision Care for the provision of optical services.

☐ By checking this box, I agree that I am signing this document electronically.

This form was completed by (enter your information here):	
Name:	Title:
Email:	Phone number:
Signature (type name if signing electronically):	Date:

Please select and list your preferred contact method.

☐ Email:	☐ Fax:	☐ Phone:

Thank you for your interest in UnitedHealthcare | March Vision Care. Please attach a signed W-9 form with this application. A member of our team will contact you shortly to review this information with you and discuss contracting. Please be sure your CAQH records are up to date and that UnitedHealthcare I March Vision Care is authorized to view your completed data.