MARCH® Vision Care

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

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

Enter all applicable service locations. If more than one location, please attach additional sheets.

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 & Hours of Operation						
Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

Select all applicable boxes relating to this location:

Services	Patients	Facility Description
☐ Exams ☐ Frames & 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)

Information provided below must match the W-9. Please include a copy of the W-9.

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 #:	
Participating Medicaid State:	Billing 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. PO Boxes are not allowed for Billing address.

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

If this is a new ownership of an existing MARCH® Vision Care practice, please complete this section:

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

By entering my name and date below, I attest to 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 MARCH® Vision Care promptly if any material change in such information occurs, whether before or after entering into an agreement with 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 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 MARCH® Vision Care is authorized to view your completed data.