United Healthcare | 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
☐ New location
☐ Change in ownership
☐ Changes to demographic information
☐ Change in billing address (only complete Section D below)

## Section A – Service Location

*Please add additional sheets or a roster, if needed:*

| Address line 1: | | |
|---|---|---|
| Address line 2: | | |
| City: | State: | Zip: |
| Phone: | Fax: | |
| Location NPI: | Email: | |
| Staff languages spoken: | Website: | |

| Billing NPI: | |
|---|---|
| **Pennsylvania providers only**<br>Billing Medicaid ID address segment (4-digit #): | Provider PA Promise ID address segment (4-digit #): |
| **North Carolina and Texas only**<br>Billing Medicaid ID address segment (2-digit #): | |

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

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**Select all applicable boxes relating to this location:**

| Services | Patients | Facility Description |
|---|---|---|
| ☐ Exams<br>☐ Frames and glasses<br>☐ Contacts<br>☐ Mobile services<br>☐ Telemedicine<br>☐ Medically necessary contacts<br>☐ Keratoconus | ☐ Accepting new patients<br>☐ Accepting existing patients<br>☐ Accepting children | ☐ Medicaid<br>☐ Medicare<br>☐ Teaching facility<br>☐ Independent office<br>☐ Retail chain (please list chain):<br><br>☐ 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. | |

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## Section B – 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 ID (State & #): |
| Languages spoken: | |
| For the location listed under Section A (Service Location), does provider routinely schedule in-person exams? ☐ Yes ☐ No<br>If No, please identify how the provider will perform exams at the service location: ☐ Fill-in (as needed) ☐ Telemedicine | |

| Name (First, Middle Initial, Last): | |
|---|---|
| Email address: | |
| Degree: | Gender: |
| Date of birth: | Social Security Number: |
| CAQH #: | NPI #: |
| License (State & #): | Medicaid ID (State & #): |
| Languages spoken: | |
| For the location listed under Section A (Service Location), does provider routinely schedule in-person exams? ☐ Yes ☐ No<br>If No, please identify how the provider will perform exams at the service location: ☐ Fill-in (as needed) ☐ Telemedicine | |

| Name (First, Middle Initial, Last): | |
|---|---|
| Email address: | |
| Degree: | Gender: |
| Date of birth: | Social Security Number: |
| CAQH #: | NPI #: |
| License (State & #): | Medicaid ID (State & #): |
| Languages spoken: | |
| For the location listed under Section A (Service Location), does provider routinely schedule in-person exams? ☐ Yes ☐ No<br>If No, please identify how the provider will perform exams at the service location: ☐ Fill-in (as needed) ☐ Telemedicine | |

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## 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 #: |
| 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: |

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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: |

**Email is our default method of contact, unless otherwise noted below.**

| ☐ I prefer to be contacted via fax. | ☐ I prefer to be contacted via 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.

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