ProviderProfileUpdateForm

Please complete the necessary sections of the form and return to visionproviderdata@uhc.com or fax to 855-250-8162. Please note that submitting this form does not confirm that the request has been completed.

Select the network the change applies to:

☐ UnitedHealthcare Vision Network / Spectera Vision Network
☐ UnitedHealthcare Community Vision Network / March Vision Network

Personal Information - REQUIRED

Requestor's name: _____

Requestor's email: _____

Requestor's fax #: _____ Requestor's phone #: _____

Managing doctor's NPI #: _____

Current billing TIN: _____

Request an update to your office's phone number

Please note this phone number will be displayed on the member directory.

Office phone #: _____

Request an update to your office's physical address or contact information

Street address: _____

City: _____ State: _____ Zip code: _____

Phone #: _____ Fax #: _____

Email: _____

Effective date: _____)_____

Request a change to your TIN (Tax Identification Number)

Please note a W9 is required

Current TIN: _____ New TIN: _____

Effective date: _____

Return to visionproviderdata@uhc.com or fax to 855-250-8162

United Healthcare

spectera | MARCH Vision Care

Request an update to the name and/or address where your checks are sent

☐ Address is the same as the office address

Payee name: _____

Street address: _____

City: _____ State: _____ Zip code: _____

Phone #: _____ Email: _____

Effective date: _____

Request an update to the name and/or address where your 1099 is sent

Please note a W9 is required

☐ Address is the same as the office address

Business name: _____

Street address: _____

City: _____ State: _____ Zip code: _____

Phone #: _____ Email: _____

Effective date: _____

Please provide the following information to better serve your patients

Office hours:

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

Languages spoken: _____

Handicap accessible: ■ YES ☐ NO

Return to visionproviderdata@uhc.com or fax to 855-250-8162