

# Credentialing Status Form

Please complete the entire form and return to [visionnominations@uhc.com](mailto:visionnominations@uhc.com) or fax to 844-558-8451.

**We kindly ask that you wait at least 60 days after submitting your application before reaching out for a status update.**

**Select the network the change applies to:**

- UnitedHealthcare Vision Network / Spectera Vision Network
- UnitedHealthcare Community Vision Network / March Vision Network

## Personal Information

Requestor's name: \_\_\_\_\_

Requestor's email: \_\_\_\_\_

Requestor's fax #: \_\_\_\_\_ Requestor's phone #: \_\_\_\_\_

## Provider information

Provider name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Provider NPI: \_\_\_\_\_ CAQH #: \_\_\_\_\_

## Address where provider should be added/credentialed

Street address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip code: \_\_\_\_\_

Phone #: \_\_\_\_\_ TIN: \_\_\_\_\_

Select if the original application included two or more locations

Date of original application submission: \_\_\_\_\_

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