Provider / Location Application

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

Select the network the change applies to:

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

Reason for completing this form:

- ☐ New provider
- ☐ New location
- ☐ Change in ownership
- ☐ Changes to demographic information
- ☐ Change in billing address (only complete Sections B and C below)

Section A – Service Location

An individual Provider / Location Application must be completed for each service location

Location name (as is should appear in the directory):		
Address line 1:		
Address line 2:		
City:	State:	Zip:
Phone:	Fax:	
Location NPI:	Website:	
Email address for plan communications:	Email address for online directory:	

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

- ☐ I prefer to be contacted via phone.

List fluent languages spoken (other than English):

Provider: Staff:

UnitedHealthcare Community Vision Network / March Vision Network only

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

Days & Hours of Operation						
Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

Select all applicable boxes relating to this location:

Services	Handicap Accessible	Facility Description
☐ Exam & full optical ☐ Exams & contacts only ☐ Exams only ☐ Optical only ☐ Mobile services ☐ Telemedicine ☐ Medically necessary contacts ☐ Keratoconus ☐ Accepting new patients ☐ Accepting existing patients ☐ Accepting children	☐ Exterior building ☐ Interior building ☐ Restroom ☐ Exam room ☐ Exam chair & table ☐ Signage/documents ☐ Wheelchair accessible ☐ Parking Number of parking spaces*: _____ **Required for UnitedHealthcare Community Vision Network only*	☐ Independent office ☐ Retail chain Please list chain: _____ ☐ Affiliation membership Please list all that apply: _____ _____ ☐ Medicaid ☐ Medicare ☐ Teaching facility

Minimum age accepted:	Maximum age accepted:
Are you interested in servicing Medicare or Medicaid members ☐ Yes ☐ No	

Section B – Taxpayer/DBA Information (As registered with the IRS)

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

Legal name of practice entity (line 1 of W9):		
DBA name (line 2 of W9):		
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 C – 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:	Email address for password resets:	
Billing NPI:		

Section D – Ownership Change

If this is a new ownership of an existing practice (UnitedHealthcare Vision Network / Spectera Vision Network and/or UnitedHealthcare Community Vision Network / March Vision Network), please complete this section

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

Section E – Provider Information

Please add additional sheets or a roster, if needed

Name (first, middle initial, last):	
Degree:	License (state & #):
Date of birth:	Gender: ☐ Male ☐ Female
Social security #:	CAQH #:
Provider NPI:	Medicaid license (state & #):
Email address:	
Languages spoken:	
***For the location listed under Section A (Service Location), does provider routinely schedule in-person exams?** ☐Yes ☐No If No, please identify how the provider will perform exams at the service location: ☐ Fill-in (as needed) ☐ Telemedicine	

Name (first, middle initial, last):	
Degree:	License (state & #):
Date of birth:	Gender: ☐ Male ☐ Female
Social security #:	CAQH #:
Provider NPI:	Medicaid license (state & #):
Email address:	
Languages spoken:	
***For the location listed under Section A (Service Location), does provider routinely schedule in-person exams?** ☐Yes ☐No If No, please identify how the provider will perform exams at the service location: ☐ Fill-in (as needed) ☐ Telemedicine	

Name (first, middle initial, last):	
Degree:	License (state & #):
Date of birth:	Gender: ☐ Male ☐ Female
Social security #:	CAQH #:
Provider NPI:	Medicaid license (state & #):
Email address:	
Languages spoken:	
***For the location listed under Section A (Service Location), does provider routinely schedule in-person exams?** ☐Yes ☐No If No, please identify how the provider will perform exams at the service location: ☐ Fill-in (as needed) ☐ Telemedicine	

**This is a required field for each provider*

By entering my name and date below, I attest to UnitedHealthcare | Spectera | 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 | Spectera | March Vision Care promptly if any material change in such information occurs, whether before or after entering into an agreement with UnitedHealthcare | Spectera | 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:

Thank you for your interest in UnitedHealthcare | Spectera | 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 | Spectera | March Vision Care is authorized to view your completed data.