

Provider Profile Update Form

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: _____

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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

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