United Healthcare

spectera | MARCH Vision Care

Provider termination form

Please email or fax your completed form to visionproviderdata@uhc.com or (855) 250-8162.

Tax Identification Number (TIN) requesting this termination: ___________________________________

Desired effective date of termination*: ____

If terminating all providers and all lines of business, the effective date must be **90 days from the date signed, per the Provider Services Agreement.*

Select the applicable network:

☐ UnitedHealthcare Community Vision Network / March Vision Network

☐ UnitedHealthcare Vision Network / Spectera Vision Network

Provider information

Please terminate the following provider(s):*

Provider name	National Provider ID (NPI)

**If additional space is needed, please attach a separate sheet, following the same format and include your TIN on the top of the page.*

Please select a reason for termination:

☐ Moved out of state ☐ Left practice/group ☐ Retired ☐ Sold practice ☐ Deceased

☐ Other (please explain): ____

____

Signature (type name if signing electronically): ______________________________ Date: ______________

Print name and title: ____

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