UnitedHealthcare | Practice Address Change Request

Please choose to let us know what you'd like to update: ◯ Add ◯ Change ◯ Delete

If you would like to update more than one address, please submit both practice address change request pages for each additional location.

SUBMITTER DETAILS

Date Today (MM/DD/YYYY) *	
Practice Type *	-Select-
Practice Tax ID Number (TIN) *	
Practice National Provider ID (NPI) Number *	
Practice Name *	
Provider Name *	
Submitter Name *	
Submitter Email Address *	
Submitter Title	
Submitter Phone *	(000) 000-0000
Submitter Phone Extension	

NPI DETAILS

Atypical Provider?	-Select-
Atypical Provider Explanation	
NPI Taxonomy Code	
NPI Issue Date (MM/DD/YYYY)	
Basis for NPI Number (Refer to NPI Table)	
NPI Level of Information (Refer to NPI Table)	

ADDRESS DETAILS

Address Type	-Select-
Do you want correspondence at this address?	-Select-
Federally Qualified Health Center (FQHC)?	-Select-
Is this the primary practice location?	-Select-
New Address Effective Date (MM/DD/YYYY)	

List Address in UHC Directory? *: Yes

If No, Select Reason: -Select-

If Care Provider Has CA-Specific Exemption, Select Reason
please attach a signed statement

- ☐ The care provider is currently enrolled in the state's Safe at Home program.
- ☐ The care provider fears for their safety or their family's safety because of their affiliation with a health care service facility or because they provide health care services.
- ☐ This location, facility or any of its care providers, employees, volunteers or patients is or was the target of threats or acts of violence within the past year.

Address Instructions: Enter OLD Phone and/or Fax Number ONLY and:
1) Add Address: Enter NEW Address ONLY
2) Change Address: Enter Both OLD and NEW Address
3) Delete Address: Enter OLD Address ONLY

Phone/Fax Instructions: Enter OLD Address ONLY and:
1) Add Phone/Fax: Enter NEW Phone/Fax ONLY
2) Change Phone/Fax: Enter Both OLD and NEW Phone and/or Fax
3) Delete Phone/Fax: Enter OLD Phone/Fax ONLY

OLD Address		NEW Address	
Street Address 1 *		Street Address 1	
Street Address 2		Street Address 2	
City *		City	
State/Territory *	-Select-	State/Territory	-Select-
Zip Code *	00000	Zip Code	
Country *		Country	

Practice Location Phone/Fax Number

Old Phone Number	(000) 000-0000	Extension	
New Phone Number		Extension	
Old Fax Number		Extension	
New Fax Number		Extension	

Website/Email Instructions:
1) Add Website/Email: Enter NEW Website and/or Email ONLY
2) Change Website/Email: Enter Both OLD and NEW Websites and/or Emails
3) Term Website/Email: Enter OLD Website and/or Email ONLY

Practice Website

Old Practice Website ☐ N/A

New Practice Website ☐ N/A

List Website in UHC Directory? -Select-

Practice Email

Old Practice Email ☐ N/A

New Practice Email ☐ N/A

List Email in UHC Directory? -Select-

LOCATION DETAILS

Telehealth Service Capability?	-Select-
Accepting UHC Members?	-Select-
Accepting VA (Department of Veterans Affairs)?	-Select-
Accepting Civilian Health & Medical Program of Veterans Affairs	-Select-
(CHAMPVA)? Accepting Medicaid Members?	-Select-
Accepting Medicare Members?	-Select-

UnitedHealthcare | Practice Address Change Request

Office Hours

Day	Open	Close		
Example	6:00 am	7:00 pm		
Monday			☐ Open 24 Hours	☐ Closed
Tuesday			☐ Open 24 Hours	☐ Closed
Wednesday			☐ Open 24 Hours	☐ Closed
Thursday			☐ Open 24 Hours	☐ Closed
Friday			☐ Open 24 Hours	☐ Closed
Saturday			☐ Open 24 Hours	☐ Closed
Sunday			☐ Open 24 Hours	☐ Closed

Practice Location Medicare/Medicaid IDs

Medicaid ID Number?	-Select-	
Medicare ID Number?	-Select-	

Specialties	Primary/Secondary	Effective Date
	-Select-	
	-Select-	
	-Select-	

Practice location expertise with individuals: (check all that apply)

- ☐ With physical disabilities
- ☐ With chronic illness
- ☐ With HIV/AIDS
- ☐ With serious mental illness
- ☐ Who are homeless
- ☐ Who are deaf or hard-of-hearing
- ☐ Who are blind or visually impaired
- ☐ With co-occurring disorders
- ☐ Who are trans gender
- ☐ Other specialties

Practice location handicap accessibility (check all that apply)

- ☐ Exam Room (E)
- ☐ Exam Table/Scale/Chair
- ☐ (T) Exterior Building (EB)
- ☐ Gurneys & Stretchers (G)
- ☐ Interior Building (IB)
- ☐ Parking (P)
- ☐ Portable Lifts (PL)
- ☐ Restroom (R)
- ☐ Radiologic Equipment (RE)
- ☐ Signage & Documents (S)

Language Details

Language	Spoken or Written?	Staff Role
	-Select-	-Select-
	-Select-	-Select-
	-Select-	-Select-
	-Select-	-Select-
	-Select-	-Select-

Medical Interpreter Line	-Select-
Medical Interpreter Line Name	
Medical Interpreter Line Number	

Practice Location Restrictions

Practice Location Age Restrictions (ages in numerals, 0-99)	
Practice Location Gender Restrictions	-Select-

Submit completed forms, required information and any additional rosters to hpdemo@uhc.com

UnitedHealthcare | Provider Demographic Change Request

If multiple updated updates are required, please provide on a separate Roster (Please see Roster Format Attached).
Please Email the Roster, W9 and any attachments to: hpdemo@uhc.com along with this form.

Please choose to let us know what you'd like to update: ◯ Add ◯ Change ◯ Delete

Date Today MM/DD/YYYY) *	
Practice Type *	-Select-
Provider Tax ID Number (TIN) *	00-0000000
Provider National Provider ID Number (NPI) *	0000000000
Practice Name *	
Provider Name *	
Submitter Name *	
Submitter Email Address *	
Submitter Title	
Submitter Phone *	(000) 000-0000
Submitter Phone Extension	

PROVIDER ADD/REMOVE DETAILS

Has the Provider Left the Group? -Select-
Effective Date Left Group (MM/DD/YYYY)
Has the Provider Joined the Group? -Select-
Effective Date Joined the Group (MM/DD/YYYY)

The Care Provider is Leaving the Group for the Following Reason? (Please check ONLY one)

☐ Retired ☐ Deceased ☐ Left Group / Practice

☐ Not Affiliated with TIN / Contract ☐ Left Service Area

☐ Incorrect Data ☐ Other (Personal, Sabbatical, Etc)

NPI DETAILS

Atypical Provider?	-Select-
Atypical Provider Explanation	
NPI Taxonomy Code	
NPI Issue Date (MM/DD/YYYY)	
Basis for NPI Number (Refer to NPI Table) NPI	
Level of Information (Refer to NPI Table)	

PROVIDER PERSONAL DESCRIPTION

Date of Birth (MM/DD/YYYY)	
Gender	-Select-
Primary Degree	
Secondary Degree	

NAME CHANGE DETAILS

The W9 required with the name change must be sent **along** with this form to make sure that the requirement is tracked as completed.

Provider Name Change? -Select-

	Last Name	First Name	Middle Initial
Current / Previous Provider Name			
New Provider Name (Attach W-9 Form)			
Name Change Date (MM/DD/YYYY)			

Provider Email -Select-
Provider Website -Select-

Old Provider Email
Old Provider Website
New Provider Email
New Provider Website

LICENSE DETAILS

Medicaid ID	-Select-	**Medicaid ID Number**	
Medicare ID	-Select-	**Medicare ID Number**	
License State	-Select-	**License State ID**	

State License Effective Date (MM/DD/YYYY)
State License Expiration Date (MM/DD/YYYY)

Please Go to the next page

Provider Demographic Change Request

PROVIDER DESCRIPTION DETAILS

Mid-Level Provider?	-Select-
Name of Supervising Physician	
Supervising Physician Specialty	
Hospitalist?	-Select-
Provider Solely in a Hospital?	
Primary Care Physician?	-Select-
Electronic Medical Record (EMR) Platform	
Indian Health Service Provider?	-Select-
Essential Community Provider (ECP)?	-Select-
Provider Name for PCP Reassignment	
Provider has Drug Enforcement Administration (DEA) Registration ID?	-Select-
Provider Drug Enforcement Administration (DEA) Registration ID	
Provider Has Buprenorphine Waiver Number?	-Select-
Provider Buprenorphine Waiver Number	
Provider Buprenorphine Waiver Number Expiration Date (MM/DD/YYYY)	
Military & Veteran Provider?	-Select-
Council for Affordable Quality Healthcare (CAQH) ID	

Hospital Affiliations with Admitting Privileges

Action	Hospital Name	Admit Privilege
-Select-		-Select-
-Select-		-Select-
-Select-		-Select-
-Select-		-Select-
-Select-		-Select-

Provider Specialty	Primary/Secondary	Board Certified?	Effective Date
	-Select-	-Select-	
	-Select-	-Select-	
	-Select-	-Select-	
	-Select-	-Select-	

Provider expertise with individuals: (check all that apply)

- ☐ With physical disabilities
- ☐ With chronic illness
- ☐ With HIV/AIDS
- ☐ With Serious Mental Illness
- ☐ Who are homeless
- ☐ Who are deaf or hard-of-hearing
- ☐ Who are blind or visually impaired
- ☐ With co-occurring disorders
- ☐ Who are trans gender
- ☐ Other specialties

Provider Cultural Competency Details

Class	Effective Date	Expiration Date
-Select-		
-Select-		
-Select-		

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Tax ID (TIN) or National Provider ID (NPI) Change Request

Please choose to let us know what you'd like to update: ◯ Add ◯ Change ◯ Maintenance ◯ Delete

Date Today (MM/DD/YYYY) *	
Practice Type *	-Select-
Tax ID Number (TIN) *	
National Provider ID Number (NPI) *	
Practice Name *	
Provider Name *	
Submitter Name *	
Submitter Email Address *	
Submitter Title	
Submitter Phone *	
Submitter Phone Extension	

Tax ID (TIN) Details

Old/Existing Tax ID (TIN)	
Old/Existing TIN Effective Date	
Reason Provider is Leaving Old/Existing TIN	-Select-
PCP or Specialist?	-Select-
If PCP, Provider Name for PCP Reassignment	
Legal Owner of Old/Existing TIN	

New Tax ID (TIN)	
New TIN Effective Date	
PCP or Specialist?	
Legal Owner of New TIN	

Submit completed forms, required information and any additional rosters to hpdemo@uhc.com

National Provider ID (NPI) Reference Table

Basis for NPI Number	NPI Number Level Of Information
C - Entity whose name is on the W-9	Tax ID number and name filed with the W-9; Legal owner of TIN - does not bill for medical services. Indicate if it's a Social Security number (SSN) or TIN
D - Department	Departnemt name: If the organization or sub-part was enumerated on the basis of a particular department, provide the Department Name that the NPI was based on, and the designate this with a "D" in the "Basis for NPI" field. Insert the Department Name in the "Level Inforamtion" field.
L - License	License number and state or state code: If the organization or sub-part was enumerated by License, provide the state or state code and License Number that the NPI was based on, and designate this with an "L" in the "Basis for NPI" field. Insert the License Number and state or state code in the "Level Inforamtion" field.
P - Place of service address	Place of service address (street, city, state, ZIP+4) If the organization was enumerated by place of service address, provide the street address that the NPI was based on and designate this with a "P" in the "Basis for NPI" field. Insert the Place of Service address in the "Level Information" field. List NPI number fore each Group/Organization Place of Service
T - Tax ID number and provider name	Tax ID number and Provider Name where care provider is not the same on the W-9, but bills with this TIN. Indicate whether the Tax ID number is a SSN or TIN.
X - Taxonomy	NUCC Taxonomy Code: If the organization or sub-part was enumerated by a NUCC Taxonomy code, provide the Taxonomy Code that the NPI was based on and designate this with an "X" in the "Basis for NPI" field. Place the NUCC Taxonomy Code in the "Level Information" field.
O - Other	Any other basis for the NPI number: Provide any other basis for NPI number in the "Basis for NPI Number" field and designate as "O", with a description of the basis for that NPI in the "Level Information" field
M - Name	Insert the name of the care provider (physician or allied health professional) in the "Level Information" field