Practice address change request form

For an easier and quicker way to submit your demographic and address changes, use My Practice Profile or CAQH instead. Find out **more details** about these enhanced options.

If you submit demographic changes using the form, please email the completed form, required information and any additional rosters to **hpdemo@uhc.com**.

If you need to update multiple addresses, you'll need to submit a form for each location.

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

Submitter details

Date today:	Practice type: Select	Practice tax ID number (TIN):
Practice National Provider Identifier (NPI) number:		
Practice name:		Provider name:
Submitter name:	Submitter email address:	
Submitter title:	Submitter phone:	Phone extension (Submitter):

NPI details

Atypical provider? ☐ Yes ☐ No	
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)? ☐ Yes ☐ No
Is this the primary practice location? ☐ Yes ☐ No	New address effective date (MM/DD/YYYY):	List address in UnitedHealthcare directory? ☐ Yes ☐ No
If no, select reason: Select		

Address details (cont.)
If care provider has CA-specific exemption, select reason: **(Please attach 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**

Old address:		**New address:**	
Street address 1:		Street address 1:	
Street address 2:		Street address 2:	
City:		City:*	
State/territory: Alabama-AL	ZIP code:	State/territory: Alabama-AL	ZIP code:
Country:		Country:	

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**

Practice location phone/fax number:	
Old phone number:	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:		**Practice email:**	
Old practice website:	N/A: ☐	Old practice email:	N/A: ☐
New practice website:	N/A: ☐	**New practice email:**	N/A: ☐
List website in UnitedHealthcare Directory? ☐ Yes ☐ No		List website in UnitedHealthcare Directory? ☐ Yes ☐ No	

	Yes	No
Telehealth service capability?	☐	☐
Accepting UnitedHealthcare members?	☐	☐
Accepting Department of Veteran Affairs?	☐	☐
Accepting Civilian Health & Medical Program of Veterans Affairs?	☐	☐
Accepting Medicaid members?	☐	☐
Accepting Medicare members?	☐	☐

Practice address change request

Office hours				
Day	**Open**	**Close**		
Example	*6:00 am*	*7:00 pm*		
Sunday			☐ Open 24 hours	☐ Closed
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

Practice location Medicare/Medicaid IDs	
Medicaid ID Number? ☐ Yes ☐ No	ID Number: Select
Medicare ID Number? ☐ Yes ☐ No	ID Number: Select

Specialties:	**Primary/Secondary:**	**Effective date:**
	Select	
	Select	
	Select	
	Select	

Practice location expertise with individuals (check all that apply)	
☐ With physical disabilities	☐ Who are deaf or hard-of-hearing
☐ With chronic illness	☐ Who are blind or visually impaired
☐ With HIV/AIDS	☐ With co-occurring disorders
☐ With serious mental illness	☐ Who are transgender
☐ Who are homeless	☐ Other specialties:

Practice location handicap accessibility (check all that apply)	
☐ Exam room (E)	☐ Portable lifts (PL)
☐ Exam table/scale/chair	☐ Restroom (R)
☐ Exterior building (EB)	☐ Radiologic equipment (RE)
☐ Interior building (IB)	☐ Signage & documents (S)
☐ Parking (P)	

Language details		
Language	**Spoken/Written**	**Staff role**
	Select	Select
	Select	Select
	Select	Select
	Select	Select
	Select	Select
Medical interpreter line ☐ Yes ☐ No		
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

Provider demographic change request form

For an easier and quicker way to submit your demographic and address changes, use My Practice Profile or CAQH instead. Find out **more details** about these enhanced options.

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

Submitter details			
Date today:	Practice type: Select	Practice tax ID number (TIN)	
Practice National Provider Identifier (NPI) number:			
Practice name:		Provider name:	
Submitter name:	Submitter email address:		
Submitter title:	Submitter phone:	Phone ext. (Submitter)	

Provider add/remove details	
Has the provider left the group? ☐ Yes ☐ No	Effective date left group (MM/DD/YYYY):
Has the provider joined the group? ☐ Yes ☐ No	Effective date joined the group (MM/DD/YYYY):
The care provider is leaving the group for the following reason? (Please check ONLY 1) ☐ Retired ☐ Deceased ☐ Left group/practice ☐ Not affiliated with TIN/contract ☐ Left service area ☐ Incorrect data ☐ Other (Personal, sabbatical, etc.)	

NPI details	
Atypical provider? ☐ Yes ☐ No	
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)**:

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Provider personal description	
Date of birth (MM/DD/YYYY):	Gender: Female
Primary degree:	Secondary degree:

Name change details		
We require you send the W-9 with the name change along with this form to make sure the requirement is tracked and complete.		
Provider name change? ☐ Yes ☐ No		
Current /previous provider name Last name:	First name:	M. initial:
New provider name (Attach W-9 form) Last name:	First name:	M. initial:
Name change date (MM/DD/YYYY):		
Provider email: ☐ Yes ☐ No		
Old provider email:	New provider email:	
Provider website: ☐ Yes ☐ No		
Old provider website:	New provider website:	

License details	
Medicaid ID number? ☐ Yes ☐ No	Medicaid ID number:
Medicare ID number? ☐ Yes ☐ No	Medicare ID number:
License state: Alabama-AL	License state ID:

Provider description details	
Mid-level provider? ☐ Yes ☐ No	Name of supervising physician:
Supervising physician specialty:	Hospitalist? ☐ Yes ☐ No
Provider solely in a hospital? ☐ Yes ☐ No	Primary care physician? ☐ Yes ☐ No
Electronic medical record (EMR) platform	
Indian health service provider? ☐ Yes ☐ No	Essential community provider (ECP)? ☐ Yes ☐ No
Provider name for PCP reassignment:	
Provider has Drug Enforcement Administration (DEA) registration ID? ☐ Yes ☐ No	
Provider Drug Enforcement Administration (DEA) registration ID:	
Provider has buprenorphine waiver number? ☐ Yes ☐ No	
Provider buprenorphine waiver number:	
Provider buprenorphine waiver number expiration date (MM/DD/YYYY):	
Military & veteran provider? ☐ Yes ☐ No	Council for Affordable Quality Healthcare (CAQH) ID

Hospital affiliations with admitting privileges

Action	Hospital name	Admit privilege
Select		Associate (ASC)
Select		Associate (ASC)
Select		Associate (ASC)
Select		Associate (ASC)
Select		Associate (ASC)

Provider specialty	Primary/secondary	Board certified?	Effective date
	Select	☐ Yes ☐ No	
	Select	☐ Yes ☐ No	
	Select	☐ Yes ☐ No	
	Select	☐ Yes ☐ No	

Provider expertise with individuals (check all that apply)

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

Provider cultural competency details

Class	Effective date	Expiration date
Select		
Select		
Select		

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

Tax ID or National Provider ID number change request form

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

Submitter details		
Date today:	Practice type: Select	Tax ID number (TIN):
National Provider Identifier (NPI) number:		Practice name:
Provider name:		Submitter name:
Submitter email address:		Submitter title:
Submitter phone:		Submitter phone extension:

Tax ID (TIN) details	
Old/existing TIN:	Old/existing TIN effective date:
Reason provider is leaving old/existing TIN: Select	
Primary care physician (PCP) or specialist? ☐ PCP ☐ Specialist	If PCP, provider name for PCP reassignment:
Legal owner of old/existing TIN:	New TIN:
New TIN effective date:	PCP or specialist? ☐ PCP ☐ Specialist
Legal owner of new TIN:	

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

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National Provider ID 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	Department 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 Information" 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 Information" 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 before 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.

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