Change Form for UnitedHealthcare BenefitServices

Please complete this form in full and email to cac@uhcservices.com. We are unable to process incomplete forms.

A. Employer Information

Employer Name:_____Phone:_____

Tax ID:_____Employer Policy #: _____

B. Employer Name or Address Change – Please provide if the employer's name or primary business address has changed.

Employer Name: _____

Street:_____City:_____State:_____Zip: _____

C. Employer Tax ID Change – Please provide if the employer's tax ID number has changed

New Tax ID: _____

D. Broker Information – Please provide if a Broker should be added to the employer's account as a contact.

Broker Name:_____Phone:_____

Email Address:_____Website Access: ☐ Yes ☐ No

E. Change in Employer's Benefit Administrator or Other Contacts

Health Insurance Portability and Accountability Act (HIPAA) privacy guidelines limit the persons to whom we may provide access to certain health information regarding your group. By completing this form, you are helping us prohibit access to protected personal and/ or group-level information by unauthorized users. By adding any individual designated to receive PHI, you are potentially granting the individual access to protected group information.

Code	Primary Contact	Name of Contact	E-mail Address	Website Access	Reimbursement Funding Notification
A= Add D = Delete U = Update Select one	Only one primary contact should be selected	First and Last Name	Complete Email Address	Yes / No	Yes / No
☐A ☐D ☐U	☐Yes ☐No			☐Yes ☐No	☐Yes ☐No
☐A ☐D ☐U	☐Yes ☐No			☐Yes ☐No	☐Yes ☐No

Please provide the name and title of the person authorizing this update.

Name:_____Title : _____

