UnitedHealthcare

Missing / Incomplete Application Update Request Form

THIS FORM IS FOR AGENT USE ONLY FOR MA/MAPD AND PDP PLANS

This form cannot be used for Medicare Supplement

Please complete ALL required fields marked with an asterisk (*) and mark the checkbox ☐ for information that needs to be updated on the application.

1 ENROLLEE INFORMATION

*First: *MI: *Last Name:

Phone: *DOB: * Medicare Number:

Permanent Address:

Street Number: PO Box: Street Name:

City: State: Zip Code:

Mailing Address: (Check if same as Permanent Address) ☐

Street Number: PO Box: Street Name:

City: State: Zip Code:

Part A Effective Date: Part B Effective Date:

Copy of Award Letter of Medicare Card: Proof of Part A: ☐ Proof of Part B: ☐

2 PLAN INFORMATION

Plan Name: Plan H-PBP (Contract):

Effective Date: Election Period:

When using SEP provide reason:

3 AGENT / SUBMITTER INFORMATION

*Agent Name: *Agent ID:

*Contact Name:

(Required if you are not Agent of Record (AOR))

*Agent Party ID or Tax Identification:

(Required if you are not Agent of Record (AOR))

*Email Address:

(where to send response)

Application Status: ☐ Missing Information/Verification Required: ☐ AOR Verification/Update: ☐

Other:

Please be specific in what action is needed or what update/changes are being requested

Supporting Documents Attached ☐

Please remit this form to: MandREnrollment@uhc.com or fax to 866-802-6062

All emails containing Personal Health Information (PHI) or Personally Identifiable Information (PII) must be encrypted using Secure Email Delivery before transmitting.