CALIFORNIA

UnitedHealthcare®

Change Request Form

Important: Please print or type all sections in black ink

Current Personal Information

UnitedHealthcare of California ID # (if applicable)	Employer Name		Group # (if applicable)
Last Name	First Name	MI	Social Security #
Address / Apt #	City	State	ZIP
Home Telephone ( )	Work Telephone ( )		Extension

Change of Personal Information

☐ Change my address/phone as indicated above.
☐ Change my name as shown above. My former name was _____

Change of Dependent Status

Newborn, adoption, marriage, open enrollment, other

	Relationship	Last Name	Social Security Number	Date of Birth (Month - Day - Year)	Effective Date of Coverage
☐ Add ☐ Delete	☐ Female ☐ Male	First Name MI	PCP or Medical Group Number	Reason ☐ Newborn ☐ Adoption ☐ Marriage ☐ Open enrollment ☐ Other*	
☐ Add ☐ Delete	Relationship	Last Name	Social Security Number	Date of Birth (Month - Day - Year)	Effective Date of Coverage
	☐ Female ☐ Male	First Name MI	PCP or Medical Group Number	Reason ☐ Newborn ☐ Adoption ☐ Marriage ☐ Open enrollment ☐ Other*	

* For "Other," please attach a letter of explanation.

Change of Other Insurance Carrier Information

	Last Name	Social Security Number	Health Coverage Name	Other Employer Name and Address
☐ Add ☐ Delete	First Name MI	Date of Birth (Month - Day - Year)	Policy No./Effective Date	
☐ Add ☐ Delete	Last Name	Social Security Number	Health Coverage Name	Other Employer Name and Address
	First Name MI	Date of Birth (Month - Day - Year)	Policy No./Effective Date	

Change of Plan Type

Plan changes can only be made during open enrollment. Before you change your plan, please confirm that your employer offers these plans. All family members must be in the same plan.

From (check one)

☐ UnitedHealthcare SignatureValue™ (HMO)
☐ UnitedHealthcare SignatureValue™ Advantage (HMO Value Network)

To (check one)

☐ UnitedHealthcare SignatureValue™ (HMO)
☐ UnitedHealthcare SignatureValue™ Advantage (HMO Value Network)

Signature required

Employee Name	Social Security #	Group # (if applicable)

Change of Primary Care Physician (PCP)/Medical Group** (HMO Only)

If your change request is received by UnitedHealthcare by the 15th of the month, the change will be effective the first of the following month; if your request is received by UnitedHealthcare after the 15th of the month, the change will be effective the first day of the subsequent month. For Example: If your PCP change request is received January 14, the change is effective February 1. If your request is received January 20, the change is effective March 1. Some restrictions apply. Please ask your employer or call UnitedHealthcare's Customer Service department.

PCP Selection (HMO Only)

Complete this "PCP Selection" section if you are changing your plan type to an HMO or HMO Value Plan from a PPO or Indemnity plan, or if you are currently enrolled in an HMO or HMO Value Plan and want to change your current PCP.

- Please select a doctor near your home for you and each of your family members from your UnitedHealthcare Provider Directory and write the name and number below.
- Please indicate your first and second choice.
- You may choose a different doctor for each member of your family.
- Did you select a doctor? If not, we will select one for you.
- Newborns remain enrolled with the mother's PCP from birth until discharged from the hospital. Please refer to your Combined Evidence of Coverage and Disclosure Form for further details.

Note: Over-age dependents require proof of full-time student status or permanent disability within 31 days of enrollment. Form cannot be processed if information is incomplete.

1	Self ☐ Female ☐ Male	Last Name First Name MI	Social Security Number - - Date of Birth (Month - Day - Year) - -	Primary Care Physician Name Medical Group Name	PCP # – OR – Group #	Primary Care Physician (PCP) Number Medical Group Number	Existing Patient? ☐ Yes ☐ No
2	Spouse ☐ Female ☐ Male	Last Name First Name MI	Social Security Number - - Date of Birth (Month - Day - Year) - -	Primary Care Physician Name Medical Group Name	PCP # – OR – Group #	Primary Care Physician (PCP) Number Medical Group Number	Existing Patient? ☐ Yes ☐ No
3	Relationship ☐ Female ☐ Male	Last Name First Name MI	Social Security Number - - Date of Birth (Month - Day - Year) - -	Primary Care Physician Name Medical Group Name	PCP # – OR – Group #	Primary Care Physician (PCP) Number Medical Group Number	Existing Patient? ☐ Yes ☐ No
4	Relationship ☐ Female ☐ Male	Last Name First Name MI	Social Security Number - - Date of Birth (Month - Day - Year) - -	Primary Care Physician Name Medical Group Name	PCP # – OR – Group #	Primary Care Physician (PCP) Number Medical Group Number	Existing Patient? ☐ Yes ☐ No

**All medical group changes must be approved by UnitedHealthcare before becoming effective. All ongoing medical care being received from referral providers must be discontinued by the effective date of your medical group change. Please have your condition evaluated by your new primary care physician.

Signature – Required for all changes

Your Signature		Date
Employer Verification/Authorized Signature	Phone # ( )	Date

UnitedHealthcare Use Only

PAC Effective Date	Verified By	Date Verified

UnitedHealthcare SignatureValue™ (HMO)
and UnitedHealthcare SignatureValue™ Advantage
(HMO Value Network)
P.O. Box 30981
Salt Lake City, UT 84130
1-800-624-8822
1-800-442-8833 (TDHI)
1-866-372-1316 (Fax)

Visit our Web site @ www.uhcwest.com

UnitedHealthcare®

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