

## Enrollee/Dependent Level Medicare Status Change Form

In order to accurately represent your Medicare information, please provide the following information.

Please indicate the following information listed on your UnitedHealthcare ID card:

UnitedHealthcare Enrollee Name: \_\_\_\_\_

UnitedHealthcare 9-digit Subscriber ID Number: \_\_\_\_\_

UnitedHealthcare 6-digit Group Number: \_\_\_\_\_

Have you, your spouse or dependent(s) enrolled in Medicare Part B (Medicare Medical Insurance)?  Y  N

- If Yes – Complete both sections 1 and 2
- If No – Complete section 2

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### Section 1

Please indicate the reason you, your spouse or dependent(s) have enrolled in Medicare Part B (Medicare Medical Insurance).

Age 65

Disability (under age 65)

Indicate the date of total disability as determined by Medicare: \_\_\_\_\_

End-Stage Renal Disease (permanent kidney failure treated with dialysis or a transplant)

Indicate where dialysis is completed:

- Home  
 Facility

Indicate the number of months of consecutive dialysis based on location of dialysis:

- Home dialysis and 30 or less consecutive months  
 Home dialysis and 31 or more consecutive months  
 Facility dialysis and 33 or less consecutive months  
 Facility dialysis and 34 or more consecutive months

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### Section 2

Signature \_\_\_\_\_ Date \_\_\_\_\_

Please sign and date this form, and return it along with a copy of any applicable Medicare card (if enrolled in Medicare Part B) to the following address:

UnitedHealthcare Eligibility  
P.O. Box 1946  
Oldsmar, FL 34677-1918  
Fax (813) 818-3724