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# Residence Verification Form

\_\_\_\_\_  
**Name**

\_\_\_\_\_  
**Medicare Claim Number**

**Current residence address (where you live):**

\_\_\_\_\_  
Street

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
Zip

\_\_\_\_\_  
County

\_\_\_\_\_  
Phone Number

**When did you move to this address?** \_\_\_\_\_  
(Month and year)

**Is this move permanent?**    YES    NO

**If the address shown above isn't permanent, what is your permanent address?**

\_\_\_\_\_  
Street

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
Zip

\_\_\_\_\_  
County

**When is your expected return date to permanent address?** \_\_\_\_\_  
(Month and year)

**Does your mail go to a different address?**    YES    NO

If yes, please show that address:

\_\_\_\_\_  
Street

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
Zip

\_\_\_\_\_  
County

**Reason for different residence and mailing addresses:**

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
**Member Signature**

\_\_\_\_\_  
**Date**