envolve®
Benefit Options

ADDING OFFICE/LOCATION FORM

Provider(s) affected by change (attach provider listing if necessary): _____

Practice Name (dba): _____ Office Contact: _____

Effective Date: _____

New Practice Name (dba): _____

New Street Address: _____

City: _____ State: _____ Zip + 4: _____

Phone: _____ Fax: _____ TIN: _____

Medicaid Location #: _____ Group (Type II) NPI (if applicable): _____

Is this location a Federally Qualified Health Center or a Rural Health Clinic? ☐ FQHC ☐ RHC

Services provided at this location (under the same Tax ID):

Glasses:	Yes ☐	No ☐
Contacts:	Yes ☐	No ☐
Routine Exams:	Yes ☐	No ☐
Medical/Surgical:	Yes ☐	No ☐
Accepting New Patients:	Yes ☐	No ☐
24 hr/7 day Coverage:	Yes ☐	No ☐
Handicap Accessible:	Yes ☐	No ☐
In-home or on-site long term care facility services:	Yes ☐	No ☐

Office Hours:

Sun:	_____	to	_____
Mon:	_____	to	_____
Tue:	_____	to	_____
Wed:	_____	to	_____
Thur:	_____	to	_____
Fri:	_____	to	_____
Sat:	_____	to	_____

Billing Information (if same as new address information above, leave blank):

Business Name: _____

Street Address: _____

City: _____ State: _____ Zip + 4: _____

For Tax ID or other changes, please call Network Management at (800) 531-2818, option 4

Fax completed form to (866) 614-4951 or email to visionnetworkmanagement@envolvehealth.com

Effective date will be 10 days from the date of receipt or the indicated effective date by the office, whichever is later.