Provider Address Form

envolve Benefit Options

☐ Adding Provider(s) ☐ Adding a Location ☐ Updating Practice Information

PRACTICE/GROUP LEGAL NAME (contracting entity):							
PRACTICE NAME (if d/b/a or other) for Directory Purposes:							
Office Address:						Ste:	
City:		St:		Zip+4:		County:	
Phone:	( )	Fax:	( )			Email:	
Tax ID #:	_____ (each unique TID requires a separate W9 form)	Group/Billing NPI:				Is this location a Federally Qualified Health Center or a Rural Health Clinic?	FQHC ☐ RHC ☐
Correspondence Address: (if different than above)				Phone:	( )	Fax:	( )
City:		St:		Zip:		Email:	

Envolve Vision Network Management Contact Information: Phone: (800) 531-2818, option 4 Fax: (866) 614-4951 Email: VisionNetworkManagement@envolvehealth.com

Provider(s) name and **title** at this location[1,2]	Primary Office?	Taxonomy	Medicare ID #	Medicaid ID #	CAQH ID[3]	DOB	Individual NPI #

[1]If there are additional providers at this location, please submit a roster list separately with all applicable information above.
[2]All participating doctors are required to complete a credentialing application (through CAQH or Envolve Vision); please let us know if we need to initiate credentialing for any current or new providers at this practice.
[3]If provider does not currently have a credentialing profile on CAQH, please enter the provider's date of birth to allow Envolve Vision to create a CAQH account for the provider.

PAY TO OFFICE:	Please provide the applicable payment office information for this entity						
Pay To Name:				Contact Person & Email (Required)			
Address:						Ste:	
City:		St.		Zip:		Phone:	Fax:

OFFICE HOURS		OFFICE DETAILS	YES	NO
Mon:	to	Is this loc. handicap accessible?		
Tues:	to	Are you accepting new patients?		
Wed:	to	Do you have age limitations to patient care? If so, what age patients do you see?		
Thurs:	to	Is there a system for 24/7 on call availability at this location?		
Fri:	to	Do you provide in-home or on-site long term care facility services?		
Sat:	to	Are other languages spoken in this office (indicate)?		
Sun:	to	Is the contracted entity (at this location) affiliated with a separate optical: store/retailer/chain (provide name)?		

Services provided by this entity/location:

☐ **Routine Exam**
☐ **Medical/Surgical**
☐ **Glasses**
☐ **Contact Lenses**

Languages(other than English) :

Optical Name:

Additional Services Provided by this entity/location: I offer the selected services in the following (indicate with an X):

Yes	Type of Residence/Location	Services Provided			
		Routine Exams	Medical/Surgical	Glasses	Contacts
☐	A Facility (Nursing Home, Assisted Living…)	☐	☐	☐	☐
☐	Schools	☐	☐	☐	☐
☐	Group Homes	☐	☐	☐	☐
☐	Private Residence	☐	☐	☐	☐
☐	Prison	☐	☐	☐	☐
☐	Other, please specify _____	☐	☐	☐	☐
☐	Services performed out of a mobile unit (van/rv)	☐	☐	☐	☐

TO LIST BRANCH OFFICES (AND SEPARATE LEGAL ENTITIES), PLEASE MAKE ADDITIONAL COPIES

****INCOMPLETE AND INNACCURATE FORMS MAY DELAY CLAIMS PROCESSING****

Submit

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