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)	Is this location a Federally Qualified Health Center, Rural Health Clinic, or an Indian Health Service?				FQHC ☐ IHS ☐ RHC ☐	
Correspondence Address: (if different than above)				Phone:	( )	Fax:	( )
City:		St:		Zip:		Email:	

Envolve Vision Customer Service Contact Information: Phone: (800) 531-2818 Fax: (866) 614-4951 Email: EBONM@EnvolveHealth.com

Provider(s) name and **title** at this location[1,2,4]	Primary Office?[4]	Taxonomy[4]	Medicare ID #[4]	Medicaid ID #[4]	CAQH ID[3]	DOB	Individual NPI #[4]

[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).
[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.
[4]Required fields for OPTICAL Providers.

PAY TO LOCATION:	Please provide the applicable payment location information for this entity						
Pay To Name:		Contact Person & Email (Required)					
Address:		Ste:		Group/Billing NPI:			
City:		St.		Zip:		Phone:	Fax:

OFFICE HOURS		OFFICE DETAILS	YES	NO	Services provided by this entity/location:
Mon:	to	Is this location handicap accessible?			☐ **Routine Exam** ☐ **Glasses** ☐ **Medical/Surgical** ☐ **Contact Lenses**
Tues:	to	Are you accepting new patients? (New Providers Must Check Yes)			
Wed:	to	Do you have age limitations to patient care? If yes, what age patients do you see?			Patient Age Range:
Thurs:	to	Is there a system for 24/7 on call availability at this location?			
Fri:	to	Are other languages spoken in this office (indicate)?			Languages(other than English):
Sat:	to	Is the contracted entity (at this location) affiliated with a separate optical: store/retailer/chain (provide name)?			Optical Name:
Sun:	to				

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

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

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

Submit

****INCOMPLETE AND INACCURATE FORMS MAY DELAY PROCESSING****

Envolve Vision, Inc. is a subsidiary of Envolve Benefit Options, Inc.