BILLING/MAILING ADDRESS CHANGE FORM

Please indicate which address should be changed by checking the applicable box below:

☐ **Change to existing billing address**
☐ **Change to existing mailing address**
☐ **Change to both the existing billing and mailing address**

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

Practice Name (dba): _____ Office Contact: _____

Effective Date: _____

New Street Address: _____

City: _____ State: _____ Zip + 4: _____

Phone: _____ Fax: _____ TIN: _____

Medicaid Location #: _____ NPI: _____

Group (Type II) NPI (if applicable): _____

If the new billing and mailing address information is different, please place the new billing information below (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.