CLOSING OFFICE FORM

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

Practice Name (dba): _____ Office Contact: _____

Effective Date: _____

Street Address: _____

City: _____ State: _____ Zip: _____

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