OFFICE RELOCATION FORM

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

Practice Name (dba): _____ Office Contact: _____

Reason for change (please check all applicable)

☐ Moving office to new location
☐ 911 address change

OLD ADDRESS

Street Address: _____

City: _____ State: _____ Zip: _____

Primary Office: ☐ Yes ☐ No

NEW ADDRESS

Effective Date: _____

Street Address: _____

City: _____ State: _____ Zip + 4: _____

Phone #: _____ Fax #: _____

Email: _____

Primary Office: ☐ Yes ☐ No

Is this location a Federally Qualified Health Center or a Rural Health Clinic? ☐ FQHC ☐ RHC
Change Billing Address? ☐ YES ☐ NO If yes, please fill out section below

NEW BILLING ADDRESS

(When adding a new billing address, a corresponding W-9 must be included with this form submission)

Street Address: _____

City: _____ State: _____ Zip + 4: _____

Phone #: _____ Fax #: _____

Email: _____

Tax ID #: _____ **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.