Provider Address Form

envolve VISION BENEFITS | Puerto Rico

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****