envolve
VISION BENEFITS | Puerto Rico

ADDING OFFICE/LOCATION FORM

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

Practice Name (dba): ______________________ Office Contact: ______________________

Effective Date: ______________________

New Practice Name (dba):______________________________

New Street Address:______________________________

City: ______________ State:______________ Zip + 4:______________

Phone:______________ Fax:______________ TIN:______________

Medicaid Location #: ______________ Group (Type II) NPI (if applicable):______________

Is this location a Federally Qualified Health Center or a Rural Health Clinic? ☐ FQHC ☐ RHC

Services provided at this location (under the same Tax ID):

Service	Yes	No
Glasses:	Yes ☐	No ☐
Contacts:	Yes ☐	No ☐
Routine Exams:	Yes ☐	No ☐
Medical/Surgical:	Yes ☐	No ☐
Accepting New Patients:	Yes ☐	No ☐
24 hr/7 day Coverage:	Yes ☐	No ☐
Handicap Accessible:	Yes ☐	No ☐

Office Hours:

Day	From		To
Sun:	________	to	________
Mon:	________	to	________
Tue:	________	to	________
Wed:	________	to	________
Thur:	________	to	________
Fri:	________	to	________
Sat:	________	to	________

Billing Information (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) 267-3022 or email to mcs@EnvolveHealth.com

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