CLOSING OFFICE FORM

Note: The effective date for closing an office is based on the timeline established in the Provider Participating Agreement.

Requestor's Contact Information: ***Complete all fields below.****

Requested By:	
Requestor's Phone Number:	
Requestor's Fax Number:	

Office and Provider Information: ***Complete all fields below.****

Office Name:	
Office Closing Address: *Street, City, State, Zip Code*	
Provider(s) Tax ID:	
Office Closing Date:	

*I understand this location will be updated as closed for **all** providers with this Tax ID.*

Authorized Signature: _____ **Date Signed:** _____

Fax completed form to: 866-267-3022
or email to:
Envolve_MCS@EnvolveHealth.com
If you have any questions, please contact Customer Service at 1-800-531-2818.