

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

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.

FAX COMPLETED FORM TO (866) 267-3022 OR EMAIL TO mcs@EnvolveHealth.com