

**BILLING/MAILING ADDRESS CHANGE FORM**

Please indicate which address should be changed by checking the applicable box below:

- Change to existing billing address
- Change to existing mailing address
- Change to both the existing billing and mailing address

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

Practice Name (dba): \_\_\_\_\_ Office Contact: \_\_\_\_\_

Effective Date: \_\_\_\_\_

New Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip + 4: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ TIN: \_\_\_\_\_

Medicaid Location #: \_\_\_\_\_ NPI: \_\_\_\_\_

Group (Type II) NPI (if applicable): \_\_\_\_\_

If the new billing and mailing address information is different, please place the new billing information below (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](mailto:mcs@envolvehealth.com)**

Effective date will be 10 days from the date of receipt or the indicated effective date by the office, whichever is later.