ENVOLVE DENTAL

Provider Data Request

envolve Benefit Options

INSTRUCTIONS:

Select the request and complete the corresponding boxes. Once the information is completed, send the form to the Provider Relations Department via email ProviderRelations@EnvolveHealth.com.

- ☐ **Add an Existing Provider to an Existing Location** — Effective Date:
- ☐ **Term a Provider from a Location** — Term Date:
- ☐ **Add a New Location – Need W9 & Roster** — Effective Date:
- ☐ **Update an Existing Location – Input New & Old Location** — Effective Date:

PROVIDER INFORMATION:

PROVIDER NAME: **NPI #:**

CAQH# Medicaid ID #:

LANGUAGE(S) SPOKEN? PRIMARY: SECONDARY: OTHER(S):

NEW OR UPDATING LOCATION INFORMATION:

PHYSICIAN GROUP/PRACTICE NAME

ADDRESS: CITY: STATE:

ZIP CODE: TELEPHONE: FAX:

EMAIL:

OFFICE HOURS

MON: THURS: SUN:

TUES: FRI:

WED: SAT:

BILLING TAX ID

☐GROUP ☐INDIVIDUAL

TAX ID:

ADDRESS:

CITY: STATE: ZIP:

OLD LOCATION INFORMATION:

PHYSICIAN GROUP/PRACTICE NAME

ADDRESS: CITY: STATE:

ZIP CODE: TELEPHONE: FAX:

EMAIL:

OFFICE HOURS

MON: THURS: SUN:

TUES: FRI:

WED: SAT:

PRIMARY TAX ID (ONE ONLY):

☐GROUP ☐INDIVIDUAL

TAX ID:

ADDRESS:

CITY: STATE: ZIP:

REQUESTOR'S SIGNATURE: DATE: