PROVIDER MAILING/BILLING ADDRESS CHANGE FORM

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

- ☐ Change existing mailing address
- ☐ Change existing billing address – Updated W-9 required
- ☐ Change both the existing mailing/billing address – Updated W-9 required
- ☐ *Check box if this update applies to all providers under this TIN*

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.***

Provider(s) Name Affected by Change:	
Provider(s) NPI:	
Provider(s) Tax ID:	
Office/Group Name:	
Old Mailing Address: *Street, City, State, Zip Code*:	
New Mailing Address: *Street, City, State, Zip Code*:	
Old Billing Address: *Street, City, State, Zip Code*:	
New Billing Address: *Street, City, State, Zip Code*:	
Phone Number:	
Fax Number:	
Effective Date of Change: **Must be greater than or equal to today's date**	

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

Fax completed form to 844-343-1250 or Email Questions to Envolve_AdvancedCaseUnit@EnvolveHealth.com