Provider Address Form

envolve Benefit Options

☐ Adding Provider(s) ☐ Adding a Location ☐ Updating Practice Information

PRACTICE/GROUP LEGAL NAME (contracting entity):									
PRACTICE NAME (if d/b/a or other) for Directory Purposes:									
Office Address:								**Suite:**	
City:			**St:**		**Zip+4:**		**County:**		
Phone:		**Fax:**			**Email:**				
Tax ID #: (each unique TID requires a separate W9 form)		**Is this location a Federally Qualified Health Center, Rural Health Clinic, or an Indian Health Service?**	☐ FQHC ☐ IHS ☐ RHC		**Have the providers in your office completed their Cultural Competency Training?**		◯ Yes ◯ No		
Correspondence Address: (if different than above)				**Phone:**		**Fax:**			
City:		**St:**		**Zip:**		**Email:**			

Envolve Vision Customer Service Contact Information: Phone: (800) 531-2818 Fax: (866) 614-4951 Email: EBONM@EnvolveHealth.com

Provider(s) name and title at this location 1,2,4	Primary Office?4	Taxonomy4	Medicare ID 4	Medicaid ID 4	CAQH ID 3	DOB	Individual NPI 4	Provider Race/Ethnicity 4
								Chose from Selection Latino
								Chose from Selection Latino
								Chose from Selection Latino
								Chose from Selection Latino Mixed

[1]**If there are additional providers at this location, please submit a roster list separately with all applicable information above.**

[2]All participating doctors are required to complete a credentialing application (through CAQH or Envolve Vision).

[3]If provider does not currently have a credentialing profile on CAQH, please enter the provider's date of birth to allow Envolve Vision to create a CAQH account for the provider.

[4]Required fields for OPTICAL Providers.

Pay to Location: Plesae provide the applicable payment location informaiton only in this Entity

Pay to Name:				**Group/Billing NPI:**					
Address:		**Ste:**		**City:**		**St:**		**Zip:**	
Phone:		**Fax:**		**Contact Person Name and Email (Required)**					

OFFICE DETAILS			OFFICE HOURS		Services Rendered at this location (Required)			
Are you accepting new patients? (New Providers Must Check Yes)	◯ Yes ◯ No	**Patient Age Range:**	**Mon:**	**to**	☐ Routine Exam ☐ Glasses ☐ Contact Lenses ☐ Medical/Surgical ☐ Telemedicine ☐ Telehealth ☐ Telemonitoring			
Do you have age limitations to patient care? If yes, what age patients do you see?	◯ Yes ◯ No		**Tues:**	**to**				
Is this location handicap accessible?	◯ Yes ◯ No		**Wed:**	**to**	**Additional Services Provided by this entity/location: I offer selected services in the following (indicate with an X):**			
Is there a system for 24/7 on call availability at this location?	◯ Yes ◯ No	**Optical Name:**	**Thurs:**	**to**	**Type of Residence/Location**		**Type of Residence/Location**	
Is the contracted entity (at this location) affiliated with a separate optical: store/retailer/chain (provide name)?	◯ Yes ◯ No		**Fri:**	**to**	**A Facility (Nursing Home, Assisted Living...)**	☐	**Schools**	☐
Are other languages spoken in this office (indicate)?	◯ Yes ◯ No	**Languages(other than English):**	**Sat:**	**to**	**Group Homes**	☐	**Private Residence**	☐
Is Sign Language offered at this location?	◯ Yes ◯ No		**Sun:**	**to**	**Prison**	☐	**Services performed out of a mobile unit (van/rv)**	☐
					Other, please specify:			

TO LIST BRANCH OFFICES (AND SEPARATE LEGAL ENTITIES), PLEASE MAKE ADDITIONAL COPIES

****INCOMPLETE AND INACCURATE FORMS MAY DELAY PROCESSING**** PAF rev 08/23