Provider Address Form

envolve VISION BENEFITS | Puerto Rico

☐ 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 W-9 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**	**Taxonomy 4**	**Medicare ID 4**	**Medicaid ID 4**	**CAQH ID 3**	**DOB**	**Individual NPI 4**	**Provider Race/Ethnicity 4**
	☐ Yes ☐ No							Chose from Selection
	☐ Yes ☐ No							Chose from Selection
	☐ Yes ☐ No							Chose from Selection
	☐ Yes ☐ No							Chose from Selection

[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 & 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	
Do you have age limitations to patient care? If yes, what age patients do you see?	◯ Yes	◯ No		**Tues:**	**to**	☐ Medical/Surgical	☐ Telemedicine		
Is this location handicap accessible?	◯ Yes	◯ No		**Wed:**	**to**	☐ Telehealth	☐ Telemonitoring		
Is there a system for 24/7 on call availability at this location?	◯ Yes	◯ No	**Optical Name:**	**Thurs:**	**to**	**Additional Services Provided by this entity/location: I offer selected services in the following (indicate with an X):**			
Is the location affiliated with a separate optical store/retailer/chain (provide name)?	◯ Yes	◯ No		**Fri:**	**to**	**Type of Residence/Location**	**Yes**	**Type of Residence/Location**	**Yes**
	Yes	**No**	**Languages (other than English):**	**Sat:**	**to**	**A Facility (Nursing Home, Assisted Living...)**		**Schools**	
Is Sign Language offered at this location?	◯ Yes	◯ No		**Sun:**	**to**	**Group Homes**		**Private Residence**	
						Prison		**Services performed out of a mobile unit (van/rv)**	
Are there any covered services that you do not offer for moral or religious objection?	◯ Yes	◯ No	If Yes, indicate which:			**Other, please specify:**			

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

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