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: ____ **BILLING TAX ID** ☐ GROUP ☐ INDIVIDUAL

OFFICE HOURS:

MON: ____ THURS: ____ SUN: ____ TAX ID: ____

TUES: ____ FRI: ____ ADDRESS: ____

WED: ____ SAT: ____ CITY: ____ STATE: ____ ZIP: ____

AGE RANGES SEEN: ____

OLD LOCATION INFORMATION:

PHYSICIAN GROUP/PRACTICE NAME ____

ADDRESS: ____ CITY: ____ STATE: ____

ZIP CODE: ____ TELEPHONE: ____ FAX: ____

EMAIL: ____ **BILLING TAX ID (ONLY ONE)** ☐ GROUP ☐ INDIVIDUAL

REQUESTOR'S SIGNATURE: ____ DATE: ____