CHANGE OF ADDRESS FORM

VALUEOPTIONS® - TRICARE®
P.O. Box 551188
Jacksonville, FL 32255-1188
PHONE: 800-700-8646
FAX: 866-429-8995

Provider Name (please print): Last _____ First _____ MI _____

Provider Social Security #:										
Provider NPI for SSN:										

Please check one: ☐ **ADD** location ☐ **CHANGE** location or information

EFFECTIVE DATE: _____ **Allow 30 days from receipt date for processing**

NEW OFFICE LOCATION: Is this a new Primary Location? **Yes** ☐ **No** ☐

Address:
*** No PO Boxes***

_____

_____

County: _____ Email: _____

Phone Number: ( ) _____ Fax: ( ) _____

Tax ID #:											***Submit W-9 if this is a new Tax ID**
NPI for this Tax ID											
Designated Primary Address for NPI:											

Tax I.D. Name (must match W-9): _____

Hours at this Location	Mon	Tues	Wed	Thurs	Fri	Sat

Handicapped Accessible? **Yes** ☐ **No** ☐ Public Transportation Accessible? **Yes** ☐ **No** ☐

A certification signature from the TIN owner/representative is required if applicant requests payment to the TIN assigned to another individual, corporation or partnership to authorize payment to the TIN owner, for TRICARE services rendered by applicant.

☐ N/A TIN is assigned to applicant

☐ TIN is assigned to another individual or entity _____

Authorization Signature by TIN Owner/Representative

NEW BILLING ADDRESS: _____

_____

Phone Number: ( ) _____ Fax: ( ) _____

LOCATION(S) TO DELETE: _____

_____

TAX ID#(S) TO DELETE: _____

DOES MAILING ADDRESS CHANGE? **Yes** ☐ **No** ☐

IF YES, NEW MAILING ADDRESS: _____

_____

Phone Number: ( ) _____ Fax: ( ) _____

DO YOU CURRENTLY HAVE ADDITIONAL PRACTICE LOCATIONS? **Yes** ☐ **No** ☐

IF YES, PLEASE ATTACH LIST.

Form Completed By (please print): _____ Date: _____