VALUEOPTIONS®
Innovative Solutions. Better Health.

TRICARE®

CHANGE OF ADDRESS FORM

RETURN COMPLETED FORM VIA FAX TO: 866-429-8995
or you may mail to: PO Box 551188, Jacksonville, FL 32255-1188

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 a 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: _____