3250 Mary Street, Suite 400 ● Coconut Grove, FL 33133 ● P. 877-336-2069 ● F. 305-234-9275

## Provider New Location & Other Contact Information due to a Disaster or Crisis

Please complete and submit this form if a disaster or other crisis requires evacuation of your area and/or relocation of your provider office(s). HealthSun needs this information to provide to our members who may call for assistance in locating their providers during emergencies.

***Note to provider groups:*** *If the physical address and/or billing address is not the same for all doctors in the group, then you must complete a separate form for each individual doctor in the group.*

Physician Name: ______________________________ NPI: ______________
Specialty: ______________________ HealthSun ID: __________
Medicare No. ______________ Medicaid No. ______________
Drug Enforcement Administration License No. ____________________
State Medical License No. ____________

Physician Name: ______________________________ NPI: ______________
Specialty: ______________________ HealthSun ID: __________
Medicare No. ______________ Medicaid No. ______________
Drug Enforcement Administration License No. ____________________
State Medical License No. ____________

Physician Name: ______________________________ NPI: ______________
Specialty: ______________________ HealthSun ID: __________
Medicare No. ______________ Medicaid No. ______________
Drug Enforcement Administration License No. ____________________
State Medical License No. ____________

Physician Name: ______________________________ NPI: ______________
Specialty: ______________________ HealthSun ID: __________
Medicare No. ______________ Medicaid No. ______________
Drug Enforcement Administration License No. ____________________
State Medical License No. ____________

Physician Name: ______________________________ NPI: ______________
Specialty: ______________________ HealthSun ID: __________
Medicare No. ______________ Medicaid No. ______________
Drug Enforcement Administration License No. ____________________
State Medical License No. ____________

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**Name of Group/Office or Medical Center:** ______________________________

______________________________________________

**Tax ID Number:** ____________________

**Physical address of location prior to disaster:**

Address: ______________________________________

______________________________________________

City: ______________________ State: __________ Zip: ______________

Office Phone: ____________________ Fax: ____________________

Office Contact Name: ______________________________

Contact's Phone: ____________________ Contact's Cell: ____________________

Contact's E-mail: ______________________________

**Physical address of new location:**

☐ **Temporary** ☐ **Permanent** **Effective Date:** ______________

Address: ______________________________________

______________________________________________

City: ______________________ State: __________ Zip: ______________

Office Phone: ____________________ Fax: ____________________

Office Contact Name: ______________________________

Contact's Phone: ____________________ Contact's Cell: ____________________

Contact's E-mail: ______________________________

**Billing/ Claims Payment Address:**

☐ **Temporary** ☐ **Permanent** **Effective Date:** ______________

Address: ______________________________________

______________________________________________

City: ______________________ State: __________ Zip: ______________

Office Phone: ____________________ Fax: ____________________

**Claims payment to (check one):** ☐ **Group** ☐ **Individual**

**Has the claims payment address changed?** ☐ **Yes** ☐ **No**

HealthSun
HEALTH PLANS
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**Additional Notes:**