



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. _____
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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**

