Optum – Physical Health

New/Additional Office Change of Address (COA)

(If adding more than one location, please complete a new form for each new location)

Group Name or First Name	M.I.	Last Name	OptumHealth 6-Digit Provider ID Number:
New Clinic Name/DBA	Old Clinic Name/DBA		Provider Type: PT/OT/SLP DC/DN/MT/ND/LAC

Is this notification related to a new location or an additional office location? ☐ **New Location** ☐ **Additional**

New Clinic/Site Address Change

Effective Date: *Required	Is this your primary location? ☐ Yes ☐ No
TAX ID NUMBER: *Required	
Street Address (PO Box NOT allowed) *Required	
Suite number	
City, State, Zip code	

Previous Clinic Address (If Applicable)

Last Date of Service:	TAX ID NUMBER:
Street Address	
Suite Number	
City, State, Zip code	

New Location Handicap Accessible ☐ Yes or ☐ No

Check All Applicable Boxes Below *Required

- ☐Parking
- ☐Exterior Building
- ☐Interior Building
- ☐Restroom Valid Values
- ☐Exam Room
- ☐Exam Table/Scales/Chairs
- ☐Gurneys & Stretchers
- ☐Portable Lifts
- ☐Radiologic Equipment
- ☐Signage & Documents

New Mailing/Correspondence Address *Required

Same as New Clinic/Site Address ☐

Street Address (PO Box allowed)
Suite number
City, State, Zip code

Gender Limitation*Required	Age Range of Patients Treated (i.e. 0-99+)*Required
☐Male ☐Female ☑Both	Minimum Maximum

New Check/Remittance Address *Required

Same as New Mailing/Correspondence Address ☐

Street Address (PO Box allowed)
Suite number
City, State, Zip code

Office Hours *Required

Day	
Monday	Closed ☐
Tuesday	Closed ☐
Wednesday	Closed ☐
Thursday	Closed ☐
Friday	Closed ☐
Saturday	Closed ☐
Sunday	Closed ☐

New Phone/Fax /Email/Web Address*Required

Office Phone	Office Fax
Office Email	Display In Directory ☐
Credentialing Email	
Web Address	

NPI Number *Required	Medicare Number	Medicaid Number
Group:	Group:	Group:
Individual:	Individual:	Individual:

List all other Health Care Providers that practice in this office (Attach Additional Sheet If Necessary).			
Name	License Type	NPI Number	Current Provider for Optum

New Location Non-English Language(s) Spoken (Check all Applicable Boxes Below) *Required

Option Codes: **P** – *Physician* **S** – *Staff* **I** - *Interpreter*

Language	***Spoken By***	***Written By***
☐ Not Applicable (NA)		
☐ American Sign Language	☐ P ☐ S ☐I	☐ P ☐ S ☐I
☐ Chinese	☐ P ☐ S ☐I	☐ P ☐ S ☐I
☐ Filipino	☐ P ☐ S ☐I	☐ P ☐ S ☐I
☐ French	☐ P ☐ S ☐I	☐ P ☐ S ☐I
☐ German	☐ P ☐ S ☐I	☐ P ☐ S ☐I
☐ Italian	☐ P ☐ S ☐I	☐ P ☐ S ☐I
☐ Korean	☐ P ☐ S ☐I	☐ P ☐ S ☐I
☐ Medi Translations Inc	☐ P ☐ S ☐I	☐ P ☐ S ☐I
☐ Russian	☐ P ☐ S ☐I	☐ P ☐ S ☐I
☐ Spanish	☐ P ☐ S ☐I	☐ P ☐ S ☐I
☐ Vietnamese	☐ P ☐ S ☐I	☐ P ☐ S ☐I
☐ Other ____________	☐ P ☐ S ☐I	☐ P ☐ S ☐I

Knox Keene - Provider Questions – California Providers Only

*Required CA Only

What percentages of your patients at this location represent the following categories? (Must add up to 100%)

Group Managed Care: __________%
Workers' Compensation: __________%
Medicare/Medicaid: __________%
Third Party Liability: __________%
Other: __________%

Please estimate the average number of patients per week you treat at this location: __________

Please Indicate How many NEW OptumHealth Patients per week you could accept at this location:

☐ None ☐ 1-5 ☐ 6-10 ☐11-15 ☐16-20 ☐21 or more

Please estimate the percentage of your time that would be allocated to treating these patients: __________%

Signature:____ Date: ______________

Printed Name: ____

PLEASE NOTE:

☐ ALL APPLICABLE FIELDS MUST BE COMPLETED IN THEIR ENTIRETY FOR PROPER PROCESSING

☐ A W-9 FORM **MUST** BE COMPLETED AND INCLUDE THE TIN EFFECTIVE DATE IF YOU ARE USING A TIN OTHER THAN THE TIN ALREADY ON FILE

☐ IF YOU HAVE A CHANGE IN NAME, PLEASE PROVIDE LEGAL DOCUMENTATION SHOWING THE CHANGE. (i.e. DRIVERS LICENSE, MARRIAGE LICENSE)

☐ **FOR SPECIALTIES DC, LAC, MT, ND, and INDIVIDUAL PT, OT, SLP:** IF YOU ARE MOVING TO A PRACTICE IN A NEW STATE, YOU MUST INCLUDE YOUR PROVIDER'S LICENSE FOR THIS NEW STATE ALONG WITH A COPY OF YOUR MALPRACTICE DECLARATIONS PAGE

Please submit the completed Change of Address Form along with all supporting documentations that are applicable to this request to:

Fax: (888) 626-1701

or

Email: network_PhysicalHealth@optum.com

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