ClaimLinx
10260 Alliance Road
Suite 325
Cincinnati, OH 45242
Phone (800) 858-1772 or (513) 677-6262
Fax (800) 858-1913 or (513) 677-6263
help@claimlinx.com
www.claimlinx.com

Address Change Form

NOTE: Please fax or mail to process your request.

Today's Date: _____ **# Pages** _____
(include coversheet)

I am a ☐ **ClaimLinx Member** ☐ **Medical Provider** *(**see below)*

Name: _____
(*Please Print Clearly – First Name,MI, Last Name*)

Location: _____
(*Please Print Clearly*)

Company: _____
(*Please Print Clearly*)

New Address: _____
(Street Address)

_____
(City, State, Zip Code)

New Email: _____

****If you are a Medical Provider, list below any other persons the address change applies to.**

Additional Medical Provider Name		
First Name	**MI**	**Last Name**