



ClaimLinx  
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***Benefit Administration That's Personal!***

**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)

**\*\*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