# Address Change Request

| Member Information | | | | | |
|---|---|---|---|---|---|
| First Name | | Last Name | | | Middle Intial |
| Date of Birth | | DPC # | | | |
| Current Address | | City | | State | Zip |
| Email Address | | | Phone | | |
| **New Address** | | **City** | | **State** | **Zip** |
| **New Email Address** | | | **New Phone** | | |

| Dependent address to be changed under this membership | | |
|---|---|---|
| **First Name** | **Last Name** | **Date of Birth** |
| | | |
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**I certify that the information on this form is correct, and I authorize EverMed DPC to make the necessary changes to update my information.**

| **Signature** | **Date** |
|---|---|
| | |

**Please mail or fax this form to:**
**EverMed DPC**
**PO Box 453**
**Camas, WA 98601**

**Fax: 360.838.1081**
**Email: secure@evermeddpc.com**
**Questions: 800-377-6099**