Provider Addition/CAQH Form

This form is for Health Alliance™ providers to notify us of any new providers who need to be added to an existing contracted group. You can also find this form online at Provider.HealthAlliance.org.

Practice Information

Provider Last Name: _____ First Name: _____ Middle Initial: _____

Sex: _____ Date of Birth: _____ Provider Degree: _____ Medicare ID: _____

CAQH Number: _____ Date CAQH Last Attested: _____

Practice/Group Name: _____

Practicing Specialty: _____ Provider NPI: _____ Tax ID: _____

Effective Date with Group: _____ DEA Number:_____ License Number: _____

Is Provider Hospital Based (i.e. Hospitalist, Pathologist, Radiologist, Anesthesiologist, Emergency Medicine)? ❑ Yes ❑ No

If applicable, supervising physician name and NPI: _____

Please note, midlevel providers must include a supervising physician.

Address 1: _____

Address 2: _____

City, State ZIP: _____

Phone Number: _____

Fax Number: _____

Provider's Hours: _____

Mailing Address (If Different from Office Location Address):

_____

_____

Billing Address (If Different from Mailing Address):

_____

_____

If you have additional office locations, attach the information to this form.

Name of individual completing this form (print only): _____

Phone Number: _____ Fax Number: _____

Email: _____ Date: _____

If you have questions or concerns, please visit Provider.HealthAlliance.org or call the Provider Services department at (800) 851-3379.

Please email this form directly to Provider.Updates@HealthAlliance.org.

Once received, the form will be reviewed. We'll contact you if we need additional information.

The CAQH portion of this form is acceptable in lieu of a credentialing application for all MD, DO and DC providers only. All other providers must complete a credentialing application.

Added Health Alliance to list of payors that can access CAQH: ❑ Mark Complete

I attest that my CAQH application is up to date with the most current information.

Provider Signature: _____ Date: _____

Health Alliance™