Provider Information Change Form

This form is for Health Alliance™ providers to notify us of any changes to their current practice structure. You can also find this form online at Provider.HealthAlliance.org or in the Forms & Resources section of hally.com for providers.

Provider Information

Effective Date of Changes:_____

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

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

Practice/Group Name: _____Provider/Practice Tax ID Number:_____

Practicing Specialty:_____ Provider NPI:_____

DEA Number:_____

License Number:_____

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

Please describe the changes being requested and indicate in comments if changes apply to all providers under the Tax ID Number.

Comments:_____

_____

_____

Please provide the information on the changes to be made below and check the applicable change.

❑ Individual Name Change

New Last Name:_____ New First Name:_____ New Middle Initial:_____

❑ Practice Name Change

•To change the practice name, a new provider roster is required for all providers affected by this change.
•A copy of a W-9 is required to change the group practice name or address. Please attach the W-9 with this form.

New Practice Name	Previous Practice Name
New Practice Name:	Previous Practice Name:

❑ Tax ID Change

New Tax ID number: _____

•A copy of a W-9 is only required to change the legal name and/or legal address with the IRS. Please attach the W-9 to this form.
•An updated provider roster is required for all practices/groups affected by this change.

Health Alliance™

❑ Address Change

*If you have additional addresses that need to be removed or added, please attach that information with this form.

Previous Address/Phone Number

Address 1:_____

Address 2:_____

City, State ZIP:_____

Phone Number: _____

Fax Number:_____

❑ Remove Previous Addresses*_____

New Address/Phone Number

Address 1:_____

Address 2:_____

City, State ZIP:_____

Phone Number:_____

Fax Number:_____

❑ Pay to Address Change

•A copy of a W-9 is only required when changing a legal name and/or address with the IRS. Please attach the W-9 with this form.

Previous Pay to Address/Phone Number

Pay to Contact:_____

Address 1:_____

Address 2:_____

City, State ZIP:_____

Phone Number: _____

Fax Number:_____

New Pay to Address/Phone Number

Pay to Contact: _____

Address 1:_____

Address 2:_____

City, State ZIP:_____

Phone Number:_____

Fax Number:_____

❑ Provider Terming from Group

Effective date of termination:_____

Reason for termination:_____

_____

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

Phone Number: _____ Fax Number:_____

Email:_____ Date:_____

If you have any questions or concerns, please visit Provider.HealthAlliance.org or call the Provider Services department at (217) 902-8937. **Failure to provide information needed could cause delays in processing.**

Please send the completed form to

Mail: Health Alliance Medical Plans • Attn: Provider Network Management • 3310 Fields South Dr. • Champaign, IL 61822

Email: Provider.Updates@HealthAlliance.org • Fax: (217) 902-9701