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.

Current Practice Information

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

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

Practice/Group Name:_____

Provider Type/Specialty: _____ Provider NPI: _____

Provider/Practice Tax ID Number:_____ DEA Number: _____

License Number:_____ Effective Date of Changes: _____

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 required to change the group practice name or address. Please attach the W-9 with 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, please attach that information with this form.

New Address/Phone Number
Address 1:_____
Address 2:_____
City, State ZIP: _____
Phone Number: _____
Fax Number: _____
Office Hours: _____

New Address/Phone Number
Address 1:_____
Address 2:_____
City, State ZIP: _____
Phone Number: _____
Fax Number: _____
❑ Remove Previous Addresses*

❑ Pay to Address 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 Pay To Address/Phone Number
Pay To Contact: _____
Address 1:_____
Address 2:_____
City, State ZIP: _____
Phone Number: _____
Fax Number: _____

Previous Pay To Address/Phone Number
Pay To Contact: _____
Address 1:_____
Address 2:_____
City, State ZIP: _____
Phone Number: _____
Fax Number: _____

❑ Provider Terming from Group

• Note: Notice required per termination language stated in contract.

Name of provider to be termed: _____
Group name: _____
Effective date of termination:_____
Reason for termination: _____
Address(es) of practice location(s) affected by 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