Provider Addition Form

This form is for Health Alliance providers to notify us of any new providers you would like to add to your existing contracted group. You can also find this form online at Provider.HealthAlliance.org or in the Forms & Resources section of YourHealthAlliance.org for providers. For non-contracted providers, complete the prospective provider form online.

PRACTICE INFORMATION

Provider Last Name:____________ First Name:____________ Middle Initial:______
Sex:________ Date of Birth:________ Medicare ID Number____________
Medicaid ID Number:____________ Practice/Group Name:____________
Provider Type/Specialty:____________ Provider Degree:____________
Provider NPI number:____________
Provider Tax ID Number:____________
DEA Number:____________ License Number: ____________
Effective Date:____________

If applicable, supervising physican name and NPI:____________

Office Location/Phone Number
Address 1: ____________
Address 2: ____________
City, State ZIP:____________
Phone Number:____________
Fax Number:____________
Office 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 (Please print): ____________
Phone Number: ____________ Fax Number: ____________
Email: ____________ Date: ____________

If you have any questions or concerns, please visit HealthAlliancePro.org or call the Provider Services Department at 217-902-8937, weekdays 8 a.m. – 7 p.m.

Failure to provide information needed could cause delays in processing.

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

PLEASE SEND THE COMPLETED FORM TO:

Mail: Health Alliance Medical Plans • Attn: Provider Network Management • 3310 Fields South Drive • Champaign, IL 61822
Email: PSC@healthalliance.org
Fax: 217-902-9702