Contracted Provider Information Change/Update Form

This form is for contracted Health Alliance providers to notify Health Alliance of any new information or changes to their current practice structure. Completed form(s) can be emailed to PSC@healthalliance.org.

The fields marked with an asterisk (*) under this section are required for all changes/updates. Failure to complete all required sections will cause form to be returned.

Contracted Provider Information:

*Contact Name: _____
*Contact Phone: _____
*Contact Email: _____
*Contact Tax ID: _____

*Type of Change/Update (please also complete corresponding section below):

☐Address (any type)	☐New Clinic Name	☐Add New Provider Information
☐Add New Location	☐Tax ID Changes (please include new W-9)	☐Phone Number (any type)
☐Provider NPI	☐Provider TIN: _____	☐PCP Status Change
☐Provider Termination	☐Provider Panel Closed	

***Effective Date of Change:** _____

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

Office Location Address/Provider NPI/Provider Termination/Add New Provider

	Current Information:	**Remove (Yes or No):**	**New Information:**
Current Clinic/Provider Name			
Tax ID Number			
Provider Specialty			
Address			
City			
State			
Zip			
Phone			
Provider NPI			
Phone			
Fax			
Office Hours			
Office Contact Email			

Correspondence Address

	Current Information:	Remove (Yes or No):	New Information:
Current Clinic/Provider Name			
Address			
City			
State			
Zip			
Phone			
Provider NPI			
Phone			
Fax			
Office Hours			
Office Contact Email			

Remit/Pay To Address

	Current Information:	Remove (Yes or No):	New Information:
Current Clinic/Provider Name			
Address			
City			
State			
Zip			
Phone			
Pay To NPI			

Tax ID Changes (include new W-9)

Applicable to All Providers? ☐Yes ☐No If No, please complete a form for each affected provider.

	Current Information:	Remove (Yes or No):	New Information:
Tax ID Number			
Current Clinic/Provider Name			
Address			
City			
State			
Zip			
Phone			
Pay To NPI			

Please email completed form(s) to PSC@healthalliance.org.

If you need to add a new practitioner, please complete the Prospective Provider Request Form.