PROVIDER UPDATE FORM

This form is designed as a fillable form for providers update their demographic information with Health One Alliance/Alliant Health Plans network. Upon completion, email this form to providerrelations@alliantplans.com, fax to (706) 529-4275 or mail to Health One Alliance, Attn: Provider Relations, PO Box 1128, Dalton, GA 30722.

Section I: Type of Change

☐ Provider Information ☐ Group Information ☐ Address Information ☐ Name Change

Section II: Provider Information

Practitioner Name: _____ Degree: _____

Former Name (if applicable): _____ Gender: ☐ M ☐ F

NPI: _____ Primary Specialty: _____

Language 1: _____ Language 2: _____

Section II: Group Information

ENTER FORMER INFORMATION

Group Name and DBA: _____

TIN: _____ Group NPI: _____

ENTER NEW INFORMATION

Group Name and DBA: _____

TIN: _____ Group NPI: _____

Section III: Address Information

If applicable, please attach a separate list of names and NPIs of all the providers in this group for whom the address change applies.

ENTER FORMER INFORMATION

Service Address: _____

Phone: _____ Fax: _____

Pay To Name: _____

Pay To Address: _____

Pay To Phone: _____ Pay To Fax: _____

Vendor Address: _____

Vendor Phone: _____ Vendor Fax:

Office Hours: _____

ENTER NEW INFORMATION

Service Address: _____

Phone: _____ Fax: _____

Pay To Name: _____

Pay To Address: _____

Pay To Phone: _____ Pay To Fax: _____

Vendor Address: _____

Vendor Phone: _____ Vendor Fax:

Office Hours: _____

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Section IV: Other Information

Please provide any additional information or documentation as necessary.

Please attach the following documentation:

- W-9(s)
- Applicable rosters

Section V: Attestation (Required)

I certify that I have examined the above information and that it is true, accurate and complete. I understand that any misrepresentation or concealment of material information may subject me to liability under civil and criminal law.

Authorized Signature: _____

Title: _____ Date: _____