THE ALLIANCE
Employers moving health care forward

Provider Organization Registration Information

Return completed form to:
The Alliance
PO Box 44365
Madison, WI 53744-4365

For health care organizations joining The Alliance network. Information will be printed in our Provider Directory as it is provided on this form. You will be sent a Directory Verification Form before any information is printed.

ADMINISTRATIVE INFORMATION

Legal name as assigned to Tax ID #:		Federal Tax ID #:	
Practice name as it should appear in our directory:		Group NPI #:	
Office mailing address:		City/St/Zip:	
Office physical address (no PO Boxes please):		City/St/Zip:	
Billing office address:		City/St/Zip:	
Website address:			
Hospital affiliation(s):			
Billing contact:	Title:	Phone:	Fax:
Billing contact address:		Email:	
Contracting contact:	Title:	Phone:	Fax:
Contracting contact address:		Email:	
Credentialing contact:	Title:	Phone:	Fax:
Credentialing contact address:		Email:	

Required enclosures:
Please include with your application copies of:

- State licensure
- Declaration page of malpractice policy

TURN THIS FORM OVER

<u>Your application is not complete without an authorized signature</u>

Practice locations should be listed on back

Provider Organization Information Form – *page 2* **Federal Tax ID#: ____________**

Please complete one column below for each LOCATION, OFFICE, URGENT/IMMEDIATE CARE CENTER, or SATELLITE CLINIC billing under the federal tax ID number shown above. Make additional copies as needed.

DIRECTORY INFORMATION

Clinic name:	
Street address:	
City/state/zip:	
Appointment phone:	Fax number:
NPI # for this location:	
Billing office (if different than page 1):	

Check all that apply:

☐ Clinic	☐ Hospital	ER phone:
☐ Urgent/Immediate Care Facility	Urgent care phone:	
☐ Home Health Agency (select services & service area)		
Services provided (Home Health only): ☐ Hospice ☐ Visiting Nurse ☐ DME/Home Med. Supplier ☐ Home IV Infusion ☐ Mail Order Supplies ☐ Orthotics & Prosthetics	Service area (see map)(HH only): ☐ Northwest Region ☐ North Central Region ☐ Northeast Region ☐ Southwest Region ☐ South Central Region ☐ Southeast Region	
☐ Inpatient Mental Health Facility		
☐ Skilled Nursing Facility		
☐ Ambulatory Surgery Center		
☐ Hospice Care Facility		
☐ MRI Services/Facility		
☐ Dialysis Center		
☐ All other types. Please specify:		
☐ Evening hours available	☐ Weekend hours available	

Clinic name:	
Street address:	
City/state/zip:	
Appointment phone:	Fax number:
NPI # for this location:	
Billing office (if different than page 1):	

Check all that apply:

☐ Clinic	☐ Hospital	ER phone:
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☐ MRI Services/ Facility		
☐ Dialysis Center		
☐ All other types. Please specify:		
☐ Evening hours available	☐ Weekend hours available	

I hereby certify that all of the responses and information provided pursuant to the questions and requests on this application are complete, true and correct to the best of my knowledge and belief. I realize that the discovery of any incomplete or untruthful answer(s) may lead to termination of my agreement with The Alliance. I have enclosed an Individual Practitioner Registration Form for each licensed medical, chiropractic, and/or mental health practitioner in our practice. Our organization has taken the appropriate steps to ensure that all of our providers maintain all licenses, certification, and liability insurance coverage required by federal, state, or local law enabling them to render health care services.

Authorized Signature: ____

Title: ______________________________ Date: ____________________