THE ALLIANCE
Employers moving health care forward®

PROVIDER UPDATE FORM

RETURN COMPLETED FORM TO THE ALLIANCE
PO BOX 44365, Madison, WI 53744-4365
Email: ProviderServices@the-alliance.org or Fax: 608.276.6626

REQUIRED

Clinic/Facility name:	
Federal TAX ID# (required):	Effective date of below changes:

CLINIC/FACILITY UPDATES

☐ **Name change** for organization	☐ Federal **TAX ID#** change (this may warrant an Amendment to your Agreement)
New name:	New Federal TAX ID#:
Old name:	*Old Federal TAX ID#:*

☐ **Address CHANGE** to existing practice location	☐ **CLOSED** practice location
New address:	*Closed address:*
Old address:	*Date closed:*

☐ **NEW Practice Location**

Location type: (check all that apply)

☐ **Clinic**	☐ **MRI Services/Facility**	☐ **Dialysis Center**	☐ **Mail Order Supplies**
☐ **Hospital** **ER PHONE:**________________	☐ **Lab (Independent Clinical Lab)**	☐ **Hospice (Inpatient)**	☐ **DME/Home Medical Supplier**
☐ **Urgent Care/Immediate Care** **URGENT CARE PHONE:**________________	☐ **Inpatient/Residential Substance Abuse**	☐ **Hospice (In-home)**	☐ **Home IV Infusion**
☐ **Convenient Care (Retail/Walk-In)**	☐ **Inpatient Behavioral Health**	☐ **Ambulance (Emergent)**	☐ **Orthotics & Prosthetics**
☐ **Ambulatory Surgery Center**	☐ **Skilled Nursing /Rehab Facility**	☐ **Medical Transport (Non-emergent)**	☐ **Hearing Aids**
☐ **OTHER (Please specify)**		☐ **Visiting Nurse**	☐ **Telemedicine services**

New address:	New Location Phone:
Current staff at this location: (Attach list if necessary)	Check if applicable: ☐Evening hours ☐Weekend hours Date location opens:

☐ **BILLING ADDRESS UPDATE** ***(Required for all location updates)***	
New address:	*Old address:*

☐ **Phone or Fax number change**	
New phone:	*Old phone:*

☐ ORGANIZATION POINT OF CONTACT ***ADDITION***

Name:	Title:
Address:	
Phone:	Fax:
Email:	

Contact type, check all that apply: ☐Billing ☐Contracting ☐Credentialing ☐Directory Updates ☐Quality

☐ ORGANIZATION POINT OF CONTACT ***REMOVAL***

Name:	Name:

TURN THIS FORM OVER – UPDATE IS NOT VALID WITHOUT AUTHORIZED SIGNATURE

PROVIDER DIRECTORY & GENERAL UPDATE FORM *(continued)*

REQUIRED	
Clinic/Facility name:	
Federal TAX ID# (required):	Effective date of below changes:

If you have a NEW Practitioner practicing at your clinic, this is the wrong form.
Please complete a Practitioner Registration form located on our website.
http://the-alliance.org/Providers/Forms/
MAKE ADDITIONAL COPIES AS NEEDED

PRACTITIONER UPDATES

☐ Current practitioner(s) will be practicing at ***ADDITIONAL*** service location(s)		
Location Address:	Practitioner Name & NPI:	Publish at this location: ☐ Yes ☐ No
Location Address:	Practitioner Name & NPI:	Publish at this location: ☐ Yes ☐ No
Location Address:	Practitioner Name & NPI:	Publish at this location: ☐ Yes ☐ No

☐ Current practitioner(s) ***NO LONGER*** practicing at following service location(s)		
Location Address:	Practitioner Name:	NPI:
Location Address:	Practitioner Name :	NPI:
Location Address:	Practitioner Name :	NPI:

☐ **TERM** current practitioner(s) ***NO LONGER*** billing under organization Federal TAX ID#		
Practitioner Name:	NPI:	Effective Date:
Practitioner Name:	NPI:	Effective Date:
Practitioner Name:	NPI:	Effective Date:

☐ **Practitioner Name Change**		
New Name:	Old Name:	Effective Date:

REQUIRED - AUTHORIZATION INFORMATION	
I hereby certify that I have the authority to make change(s) on behalf of the organization listed above.	
Name:	Title:
Email:	
Signature:	Date:

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