



Provider Add Form

*Required Fields: Partially completed forms may not be able to be processed

CAQH ID Number _____

Provider Information

	Last	First	Middle	Suffix	Degree
Name					
Specialty					
Indiv. NPI		DOB		Gender	
SSN		License #		License St	

Practice Information

Practice Name					
Group NPI			Tax ID		
Contact Name			Title		
Email			Phone		

Physical Service Address

Street					
City		State		Zip	
Phone		Fax			

Billing Address

Street					
City		State		Zip	
Phone		Fax			

Signature

Date

Please print this and mail to: Allegiance Provider Direct
P.O. Box 3018 - Missoula, MT 59801
or fax to (406) 523-3139

If you do not have a CAQH account, please contact
credentialing@askallegiance.com for more information