Provider Remove Form

*Partially completed forms may not be able to be processed

Practice Name		Tax ID	
Group NPI		Date	
Submitted By		Phone	
Title		Email	

Provider Information

	Provider Name	NPI	End Date	Reason
1				
2				
3				
4				
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7				
8				
9				
10				

You may receive a phone call requesting confirmation of any of this information.

Please print this and mail to:
Allegiance Benefit Plan Management, Inc.
C/O Provider Relations
P.O. Box 3018, Missoula, MT, 59801
or Fax to (406) 523-3139