

**Provider Change Request Form**

**Directions:** Please complete this form to notify the Reliance eHealth Collaborative of providers (physicians, nurse practitioners, physician assistants) who are joining your practice or who are leaving the practice. Reliance staff will contact you when the change has been completed.

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| **Practice/Facility Information** |
| Practice/Facility Name |   |
| Organization NPI # |  |
| Change Request Submitted by: |   |
| Effective Date(s) of Change *(Note if different dates for provider changes)* |  |
| Phone # |  ( ) | Fax # |  ( ) |
| E-mail Address |   |
| Address #1 |   |
| Address #2 |   |
| City |  | State |  | Zip Code |  |

|  |  |
| --- | --- |
|  |  |
| Practice Administrator Name (print)  |
|  |  |  |
| X |  |  |
| Practice Administrator Signature |  | Date |



Please list the providers that are to be added or removed from Reliance:

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Add** | **Remove** | **Full Legal Name****(No Nick Names)****Last First M.I.** | **Credentials****(MD, DO, PA, APN)** | **DOB****Month/****Day/Yr** | **NPI #** | **Provider License #** | **Provider Specialty** |
| [ ]  | [x]  | *Doe* | *Jane* | *S.* | *DO* | *1/26/65* | *1234567890* | *C1-0123456* | *Pediatrics* |
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**Send the completed form to Reliance via:**

**Email –** **support@RelianceHIE.org** **Mailing Address – 1175 E. Main Street, Suite 1A, Medford, Oregon 97504**