ALLIANCE HEALTH SYSTEMS, IPA

CONIFER HEALTH SOLUTIONS®

EFFECTIVE DATE OF CHANGE: __ / __ / 20__

ADDITION – CHANGE – TERMINATION (ACT) FORM

– Please make required changes, SIGN & DATE at the bottom and return this to Conifer via Account Representative.

Line of Business:			
Commercial ☐	Medi-Cal ☐	Medicare ☐	Healthy Families ☐

PROVIDER DEMOGRAPHIC				
Provider Name:		Degree:		
Address:				
City:	State:	Zip:		
Phone:	Fax:	Email:		
DT-LA POD ☐	ELA-SLA POD ☐	SGV POD ☐	OC POD ☐	OOA POD ☐
NPI:	SSN:	Provider ID:		
TIN:	License:	Specialty:		

ACTION			
Add ☐	Change ☐	Delete ☐	
Provider Group / Name ☐	TIN ☐	Telephone ☐	Fax ☐
Primary Address ☐	Secondary Address ☐	Billing Address ☐	
Contract Change ☐	Amendment Change ☐	Rate Change ☐	
Panel Closure: Yes ☐ No ☐			
Other ☐			
Change "FROM" Instructions:			
Change "TO" Instructions:			

TERMINATION		
Effective Date:	Reason:	Tranfer Members: Yes ☐ No ☐
Notes / Comments:		

DULY AUTHORIZED APPROVAL SECTION:	
Print Name	Title
Sign Name	Signature Date