



Provider Demographic Attestation Form

The Alameda Alliance for Health (Alliance) Provider Demographic Attestation Form is confidential. Filling out this form will help us better serve you.

Instructions

1. Please print clearly or type in all of the fields below.
2. Please complete the form and return it via fax to the Alliance at **1.855.891.7257**.

For questions, please call the Alliance Provider Services Department at **1.510.747.4510**.

Please Note: Only complete the form if there are any changes.*

Section 1: Provider Information

Provider/Clinic Name: _____

Tax ID Number (TIN): _____

Site Address: _____

City: _____ State: _____ Zip Code: _____

Main Phone Number: _____ Fax Number: _____

Hours of Operation: _____

Clinic Email Address: _____

Languages Spoken: _____

Accepting Patients: Yes No Only Existing

Provider Name	Provider NPI	Ethnicity (optional)	Is this provider still affiliated with this practice?
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No

Update Completed Date (MM/DD/YYYY): _____

Notes:

*Health and Safety Code 1367.27 require providers to attest to their Provider Directory data. For detailed information that the Alliance has in its directory or directories regarding your provider or provider group, including a list of networks and plan products that include the contracted provider or provider group, please log into the Alliance Provider Portal and click the **Provider Demographic Attestation** icon on the home page of the portal. You may also use this option to attest that all information is correct or notify us of any changes electronically using an online interface. Failure to respond to or attest to your information may result in a delay of payment or reimbursement of a claim.