**Provider Demographic Attestation Form**

**INSTRUCTIONS**:

1. Please print clearly.
2. Please return form by fax to Alameda Alliance for Health (Alliance)

Fax Number: **1.855.891.7257**

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

|  |  |
| --- | --- |
| **PROVIDER INFORMATION** | |
| PROVIDER/CLINIC NAME | PROVIDER TAX ID |
| SITE ADDRESS | |
| MAIN PHONE NUMBER | FAX NUMBER |
| HOURS OF OPERATION | |
| CLINIC EMAIL ADDRESS | |
| LANGUAGES SPOKEN | ACCEPTING PATIENTS  **🞎**  YES **🞎**  NO  **🞎**  ONLY EXISTING |

|  |  |  |
| --- | --- | --- |
| **PROVIDER NAME** | **PROVIDER NPI** | **IS THIS PROVIDER STILL AFFILIATED WITH THIS PRACTICE?** |
|  |  | **🞎**  YES **🞎**  NO |
|  |  | **🞎**  YES **🞎**  NO |
|  |  | **🞎**  YES **🞎**  NO |
|  |  | **🞎**  YES **🞎**  NO |
|  |  |  |

|  |
| --- |
| **Date Update Completed** *(MM/DD/YYYY)***:** \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ |

**Notes:**