Provider change request

Add or removal

Facility name:		**Submitter code:**	
Street address			
City, State and Zip			
Contact name:		**Phone #:**	

LabLink client: ☐ No ☐ Yes

Additions:

All fields must be completed					***For Internal use only***			
Complete legal name (Last, First, MI)	**Credentials**	**Specialty**	**NPI**	**Effective date**	FMP	Provider edit	Reqs	LabLink

Removals:

Complete as many fields as possible					***For Internal use only***			
Complete legal name (Last, First, MI)	**Credentials**	**Allina PID**	**New practice location**	**Effective date**	FMP	Provider edit	Reqs	LabLink

Name changes: For provider name changes, contact your Account Representative or email the account representative email below.

Email the completed form to AllinaHealthLaboratoryAccountRepresentatives@allina.com