Provider Update Form

☐ Provider Adding ☐ Provider Deactivations

Provider Information	
Name of Practice/Organization (Primary):	
Provider Name:	
Provider NPI:	
Provider Credentials:	
Provider Direct Mail Address:	

I authorize the above provider change for my organization.

RHIO Administrator Signature **Date**

PLEASE NOTE: If the provider treats patients at multiple facilities, provider will only be removed from your facility.

PLEASE SUBMIT TO SUPPORT@HEALTHECONNECTIONS.ORG
OR FAX TO 1-315-407-0053.