Allegiance Preferred Provider Agreement Request

I, _____ (provider name/practice) request that Allegiance Benefit Plan Management, Inc. offer a Preferred Provider Agreement to my practice. This will assure that my patients will have access to cost effective healthcare service pricing.

Allegiance Benefits Plan Management, Inc.
Provider Services
PO Box 3018
Missoula, MT 59806
Phone: (406) 721-2222 | Fax: (406) 523-3139
ADirect@AskAllegiance.com

Date	
Physician or Practice Name	
Specialty	
Tax ID	
Address	
City, State, Zip	
Contact Person	
Phone	
Fax	
Office Email	

Please send this completed form to us at ADirect@AskAllegiance.com

Thank you for your time and effort.