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 Benefit Plan Management
Provider Services
PO Box 3018
Missoula, MT 59806
Phone: (406) 721-2222 Fax: (406) 523-3139

_____
Date

_____
Physician or Practice Name

_____
Specialty

_____
Tax ID

_____
Address

_____
City State ZIP

_____
Contact Person

_____ _____
Phone Fax #

_____
Office E-mail Address

Thank you for your time and effort.

Submit