Hometown Health

# PROVIDER CONTACT UPDATE

**Thank you for taking the time to update Hometown Health with your current practice information.**

*We appreciate your help!*

## PLEASE PROVIDE THE FOLLOWING CONTACTS

**Practice Name** _____

Address _____

City _____ State _____ Zip _____

Phone _____ Fax _____ Practice Email _____

**Office Manager** _____

Address _____

City _____ State _____ Zip _____

Phone _____ Fax _____ Email _____

**Billing Contact** _____

Address _____

City _____ State _____ Zip _____

Phone _____ Fax _____ Email _____

**Contracting Contact** _____

Address _____

City _____ State _____ Zip _____

Phone _____ Fax _____ Email _____

**Credentialing Contact** _____

Address _____

City _____ State _____ Zip _____

Phone _____ Fax _____ Email _____

UPON COMPLETION, PLEASE FAX TO HOMETOWN HEALTH ATTENTION "**Provider Relations**"
AT **775-982-8003** OR EMAIL TO **HTHProviderRelations@hometownhealth.com**