Carolina Behavioral Health Alliance
BENEFITS ADMINISTRATION

CBHA Provider Location Information Sheet

Provider name_____

Practice name_____

Primary - Practice Physical Address
_____
_____
_____

Secondary – Practice Address
_____
_____
_____

Mailing address

_____
_____
_____

Effective date (of new or change of address)
_____

End date (of an old address if leaving)
_____

Payment address
_____
_____
_____

ADDITIONAL NOTES

_____

_____

Tax ID#_____

Individual Provider NPI#_____

Billing Provider NPI# _____

Location NPI# _____

Practice Phone# _____

Practice Fax#_____

Email Address_____

Please email this form to credentialing@cbhallc.com

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