UMPQUA HEALTH

Facility/Clinic Name	

Form Completed By:	Date Form Completed:
Received by:	***Date Received***

***For provider updates, please complete this section:**

Provider's First, Middle, Last:	
☐ Primary Address Update:	
☐ Secondary Address Update:	
☐ Website:	☐ Provider's Office Email:
☐ Office Hours:	☐ Provider's Office Hours:
☐ Taxonomy update	
☐ Credential(s) Update:	
☐ License Update:	
☐ Medicare ID # (PTAN/Legacy):	

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COMMENTS / NOTES:
Please email form to UHNProviderServices@UmpquaHealth.com or fax to: (541) 229-4782