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Behavioral Solutions of California

Clinician Add/Change Application Form

INSTRUCTIONS

(1) Before completing this form, it is essential to review your current demographic information online to ensure that the requested changes align with information we currently have on record. In many cases, non Tax Identification Number (TIN) related transactions can be completed online without the use of this form.

(2) Please take this opportunity to validate all of your information and make the necessary modifications via this form or at providerexpress.com under Transactions → My Practice Info.

(3) Submit one Clinician Add/Change Form per existing or new TIN. Do not attempt to submit changes pertaining to multiple TIN's on a single form except for TIN changes, where the old TIN is being deleted and a new TIN is being added at the same time with the same effective date.

(4) This document is a "FORM" and the preferred method of completion is to populate each field electronically. Hand-written responses may result in delayed and/or inaccurate processing.

(5) Your CAQH application needs to match our records to prevent any disruptions in your network status. Updates to CAQH do not update our systems automatically; CAQH must be updated separately.

(6) **RETURN THIS SIGNED FORM AND APPLICABLE ATTACHMENTS TO YOUR NETWORK MANAGEMENT TEAM.** To locate the fax numbers for your Network Management Team go to providerexpress.com → Contact Us → Network Management.

If you have questions, please contact Network Management at 877-614-0484.

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Clinician Add/Change Application Form

What Would You Like To Do?	Here's What You Need to Submit
☐ **ADD NEW (ADDITIONAL) TIN AND RELATED PRACTICE INFO** *If also deleting a TIN, also check 'Delete Existing TIN'*	☐ Complete all sections of form ☐ Complete, Sign and Date W-9 Form
☐ **DELETE EXISTING TIN** *At least one active TIN must remain associated with your Individual Contract. If you wish to terminate your participation, please refer to your provider manual and contract for termination requirements.*	☐ Complete Section 1 only (No Attachments Required)
☐ **CHANGE EXISTING TIN TO A NEW TIN (NO DEMOGRAPHIC CHANGES)** *If changing TINs and making demographic updates, select both Add New and Delete Existing TIN instead*	☐ Complete Section 1 only ☐ Complete, Sign and Date W-9 Form
☐ **ADD NEW PRACTICE LOCATION IN A NEW STATE FOR EXISTING TIN** *If you are adding a new practice location in MD, NC, or AR, and are not currently contracted with us in that state, do not complete this form. Instead follow the "Join Our Network" link at* providerexpress.com. *If you no longer practice in currently contracted state, please also check 'Delete Existing TIN"*	☐ Complete Sections 1 and 2 in addition to Section 8 (License Information) and any other relevant sections. ☐ Attach Federal DEA Registration and/or State Controlled Substance Permit (CDS) for Prescription Privileges in new state, if applicable
☐ **DEMOGRAPHIC CHANGES ONLY** *Add, modify, and/or delete demographic practice, remit, mailing, recredentialing, and/or 1099 address information for currently contracted state(s).*	☐ Complete Section 1 along with any sections of form applicable to information that is changing (No attachments required)

TIN = Tax Identification Number and/or EIN (Employee Identification Number)

1. REQUIRED INFORMATION FOR ALL REQUESTS

Last Name	**First Name**	**Middle Initial**	**NPI** (Type I – Individual)
Individual Medicaid Number	**Individual Medicare Number**		**Taxonomy**
***EFFECTIVE DATE OF THIS CHANGE:**			
**Effective dates should be no earlier than 30 calendar days prior to the date of submission and no greater than 90 days after submission. If effective date is outside of these parameters, please include a reason for consideration:*			

SOCIAL SECURITY #		**TIN TO BE DELETED** (if applicable)	
TIN (Current or New TIN for this update)		**TIN OWNER NAME TO DELETED** (if applicable)	
TIN OWNER NAME (As registered with IRS)		**REASON FOR DELETING TIN** (if applicable)	

2. PRACTICE LOCATION INFORMATION

☐ **This is a private home residence**
☐ **This an inpatient facility address (not subject to outpatient referrals)**
☐ **This is the <u>primary</u> practice address for this TIN**

If Primary Practice Address is checked, any existing *primary practice address* on record for this TIN will be re-designated as a secondary practice.

Name of Group/Clinic/Office			
Practice Address		County	
City	State	Zip	
Daytime Phone Number	Emergency/After Hours Phone	***Secure Fax Number**	Other Fax Number
Clinic/Group Medicare Number	Clinic/Group Medicaid Number	NPI (Type II) Organization	
Office Contact Name	Office Contact Phone Number	Email Address	

Are you available for evening appointments? Yes ☐ No ☐	Are you available for weekend appointments? Yes ☐ No ☐	Is the office handicap/ wheelchair accessible? Yes ☐ No ☐	Is the office near public transportation? Yes ☐ No ☐	Are you accepting new members? Yes ☐ No ☐

3. REMIT / BILLING ADDRESS

☐ Same as Primary Practice Location (only one remit address per TIN allowed)

☐ Same as Group Practice Remit Address (for Group Contracted TIN's only)

If adding a new remit/billing address for existing TIN, the existing remit/billing address for that TIN on record will be un-designated as a remit/billing address.

Name of Group/Clinic/Office		Phone Number	Billing Contact
Address		County	Billing Contact Phone Number
City	State	Zip	

4. ADDITIONAL (NON PRIMARY) PRACTICE LOCATION INFORMATION

☐ **This is a private home residence**
☐ **This an inpatient facility address (not subject to outpatient referrals)**

Name of Group/Clinic/Office			
Practice Address		County	Federal Tax ID
City	State	Zip	
Daytime Phone Number	Emergency/After Hours Phone	***Secure Fax Number**	Other Fax Number
Clinic/Group Medicare Number	Clinic/Group Medicaid Number	NPI (Type II) Organization	
Office Contact Name	Office Contact Phone Number	Email Address	

Are you available for evening appointments? Yes ☐ No ☐	Are you available for weekend appointments? Yes ☐ No ☐	Is the office handicap/ wheelchair accessible? Yes ☐ No ☐	Is the office near public transportation? Yes ☐ No ☐	Are you accepting new members? Yes ☐ No ☐

Additional practice addresses can be submitted via separate sheet of paper

5. TAX INFORMATION ADDRESS FOR 1099 MAILINGS

☐ Same as Primary Practice ☐ Same as Remit / Billing

Enter either a PO Box or Street Address, not both. This address must exactly match W-9.

Name of Group/Clinic/Office		Phone Number
Address		County
City	State	Zip

6. MAILING ADDRESS FOR GENERAL CORRESPONDENCE

☐ Same as Primary Practice ☐ Same as Remit / Billing

Name of Group/Clinic/Office		Phone Number	Contact Name
Address		County	
City	State	Zip	

7. DELETE EXISTING ADDRESS(ES) (not applicable for adding a new TIN)

At least one primary practice location must remain for this TIN. If you are deleting a practice address that is also your current primary practice location on record, a new primary practice address needs to be added or designated above. Likewise, if you are deleting an address that is also your remit address on record, a new remit address needs to be added.

Address
Address

8. LICENSE INFORMATION

State	Full Name as it appears on License	License Type	License Number	Date First Issued	Expiration Date

9. HOSPITAL ADMITTING PRIVILEGES, IF APPLICABLE

Name of Hospital		Type of Privileges		
Address	City	State	Zip	Phone Number
Name of Hospital		Type of Privileges		
Address	City	State	Zip	Phone Number
Name of Hospital		Type of Privileges		
Address	City	State	Zip	Phone Number

10. RECREDENTIALING ADDRESS

Unlike all other addresses on this form, the Recredentialing Address is per Clinician, *not* per Tax ID. Please be sure that if your recredentialing address needs to be updated, you do so at this time.

☐ Same as Primary Practice ☐ Same as Remit / Billing

Address (Street Address Only, no P.O. Boxes)	Phone Number	(Secure) Fax Number
City	State	Zip
Email Address	Contact Name	Contact Phone Number

Optum/OptumHealth Behavioral Solutions of California

Authorization and Release

I understand and acknowledge that I am changing information related to my participation status with Optum/OptumHealth Behavioral Solutions of California (Optum) and that I am responsible for providing all information reasonably requested by Optum.

I hereby certify that all information contained in this change application and all its attachments is accurate, true and complete. I understand that I retain the right to review any information submitted to Optum in support of my application.

I understand that it is my responsibility to promptly notify Optum of any changes or additions to the information contained in the application and that all the information provided during the application process is subject to Optum's investigation and review. I understand and agree that if any information contained in this application is determined to be false or constitutes a material misstatement, my application may be denied or my participation status may be involuntarily terminated. I understand that in the event that my application is denied or my participation status is terminated involuntarily, Optum may be required to submit a report to the National Practitioner Data Bank and to state licensing authorities.

I understand I have the right to review and correct erroneous information obtained by Optum to evaluate my application. This does not include references, recommendations, or other peer-review protected information. The review must take place within 6 months of this application and corrections must be made in writing, within 30 days of the review.

By changing information related to my participation status, I hereby authorize Optum, its affiliates and successors, to obtain any information that may be relevant to an evaluation of my professional qualifications, ability, and character to practice medicine, including information about disciplinary actions or other confidential or privileged information, and other credentials. I hereby authorize all individuals, institutions and entities with which I have been or am now associated, including but not limited to, educational institutions, hospitals, clinics and health plans, professional liability carriers, licensing boards, specialty boards, professional societies, government agencies, and any other pertinent sources, to provide any relevant information requested by Optum or its representatives. I also consent to the inspection by representatives of Optum of all facilities and/or documents that may be material to my request for participation status with Optum.

I hereby release from liability all individuals, institutions and entities and their respective agents from liability for all acts performed in good faith and without malice in connection with the investigation and review of this application, my participation status with Optum and the release and exchange of information by such individuals, institutions and entities. This release shall be in addition to any other applicable immunity provided by state and federal law. Optum is bound by all state and federal confidentiality laws.

I understand and agree that the authorization and release given by me is irrevocable as long as I am a participating clinician with Optum. This authorization to obtain confidential information about me remains in effect until I notify Optum otherwise, in writing, except as otherwise provided under state law.

I further acknowledge that I have read and understand this Authorization and Release.

By signing this attestation I acknowledge that I have hospital admitting privileges in good standing, if applicable, and that I carry professional liability insurance coverage of at least $1,000,000/$3,000,000 as a physician or $1,000,000/$1,000,000 as a non-physician clinician.

I warrant that I have the authority to sign this application, on my own behalf, and on behalf of any entity or organization for which I am signing in a representative capacity. I understand that if this application is accepted by Optum, I will be bound by the terms of the Agreement, of which this application is a part. I have read and understand the terms of the Agreement, and agree to be bound by them, and accept the published rates for my level of licensure.

A copy of this document shall have the same effect as the original.

Printed Name of Applicant: _____

Original Signature of Applicant: _____

IMPORTANT TAX DOCUMENT
SUBSTITUTE FORM W-9

Request for Taxpayer Identification Number

As part of the contracting process, we are requesting that you complete this Substitute Form W-9. We are required by law to obtain this information from you when making a reportable payment to you. If you do not provide us with this information, your payments may be subject to federal income tax backup withholding. Also, if you do not provide us with this information, you may be subject to a penalty imposed by the Internal Revenue Service under Section 6723 of the Internal Revenue Code.

This information must be consistent with the data provided on Page 1 of the application (clinic information).

1. Taxpayer Name _____
   (To whom the check is payable) (A legal entity name if a corporation or partnership)

   Doing Business as: DBA _____
   (A division name if a corporation or the name of the business if a sole proprietor)

2. Taxpayer Address _____

   _____

   _____

3. Taxpayer Identification Number

   a. Corporation _____
   (List employer identification number)

   b. Partnership _____
   (List employer identification number)

   c. Sole Proprietorship _____
   (List social security number or employer identification number)

   d. Tax Exempt Entity _____
   (List employer identification number)

   e. Other – Please Explain _____

4. Effective Date of Taxpayer Name & TIN _____

5. Form Completed By _____
   (Print name)

6. Signature _____
   (Signature)

7. Today's Date _____

8. Daytime Phone Number _____

PLEASE NOTE: INFORMATION REPORTED ON LINES 1-3 MUST BE CONSISTENT WITH DATA ON FILE WITH THE IRS AND SOCIAL SECURITY ADMINISTRATION.