



Completed by:

Contact email:

Established Provider Information Change Form

Type: Add ☐ Term ☐ Change ☐		What?	
Effective Date of Add/Term/Change:		Billing Contact & Phone:	
Corporate Name:		Clinic/Facility Name:	
List in Provider Directory? ☐ Yes ☐ No			
Tax ID (as filed with IRS):		OLD Tax ID (if applicable):	

EXISTING or NEW Billing Information		OLD Billing Information (if applicable)	
Name:		Name:	
NPI:		NPI:	
Address:		Address:	
City/State/Zip:		City/State/Zip:	
Phone:	Fax:	Phone:	Fax:
Website Address:		Website Address:	
Hours:		Hours:	

EXISTING or NEW Site Information (Site 1)		OLD Site Information (if applicable) (Site1)	
Name:		Name:	
NPI:		NPI:	
Address:		Address:	
City/State/Zip:		City/State/Zip:	
Phone:	Fax:	Phone:	Fax:
Hours:		Hours:	

EXISTING or NEW Site Information (Site 2)		OLD Site Information (if applicable) (Site 2)	
Name:		Name:	
NPI:		NPI:	
Address:		Address:	
City/State/Zip:		City/State/Zip:	
Phone:	Fax:	Phone:	Fax:
Hours:		Hours:	

<i>Provider/Facility Information</i>									
List in Directory? (Y or N)	NPI	Name (First, MI, Last)	Degree	Specialty	Site # (1, 2,...)	CAQH ID	Effective Date	Term Date	*Telehealth Y/N

*Telehealth is defined as professional consultations, office visits, and office psychiatry services through technology-based services/virtual check-in, remote evaluation of pre-recorded patient information, and inter-professional internet consultation.

Add	Term	<i>Mental Health Services</i>	Add	Term	<i>Substance Related Disorder Services</i>
☐	☐	Adult Inpatient Mental Health Services (IAMH)	☐	☐	Adult Inpatient Substance Related Disorder Services (IASA)
☐	☐	Adolescent Inpatient Mental Health Services (ITMH)	☐	☐	Adolescent Inpatient Substance Related Disorder Services (ITSA)
☐	☐	Adult Outpatient Mental Health Partial Hospital/Day Program Services (OAMH)	☐	☐	Adult Outpatient Substance Related Disorder Services (OASA)
☐	☐	Adolescent Outpatient Mental Partial Hospital Day Treatment Services (OTMH)	☐	☐	Adolescent Outpatient Substance Related Disorder Services (OTSA)

Authorized Signature: _____ Printed name: _____ Title: _____ Date: _____

Return completed, signed form via: Email: Credentialingahp@optum.com or Fax to: 763.847.4814.