

\*Provider # \_\_\_\_\_  
(Optima use only)

### OPTIMA BEHAVIORAL HEALTH Provider Update Form

Please fax to:  
757-552-7114 - Hampton Roads/NC  
804-510-7459 - Central/Western VA

**Change Requested:**

- Changing Practice
- Additional Practice
- Additional Location (for current practice)
- Physical Address
- Billing Address
- Telephone/Fax
- Tax ID (W9 form required)
- Name Change
- Leaving Practice
- Add/Change Provider Email
- Add/Change Practice Email
- Other (use comments)

**Effective Date:** \_\_\_\_\_

**Provider:** Name \_\_\_\_\_ SS# \_\_\_\_\_

NPI \_\_\_\_\_ Taxonomy: \_\_\_\_\_ \*Specialty Code: \_\_\_\_\_  
(Optima use only)

License Type: \_\_\_\_\_ VA License#: \_\_\_\_\_ Degree \_\_\_\_\_

VA MCD# \_\_\_\_\_ MCR# \_\_\_\_\_ DEA# (if applicable) \_\_\_\_\_

Board Status:  Cert  Not Cert  Elig  Grandfathered  Undersv **Provider Email:** \_\_\_\_\_

**Practice:** Name: \_\_\_\_\_ \*Vendor # \_\_\_\_\_  
(Optima use only)

Tax ID \_\_\_\_\_ Group NPI \_\_\_\_\_

Practice Manager: \_\_\_\_\_ Practice Email: \_\_\_\_\_

**Primary Office Address:** \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_ Is this a confidential fax line?  Y  N **AUTOFAX**

**Billing Office Address** (if different from primary): \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_

**Additional Office Location:** \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_

Which Address Is the Mailing Address? (optima use only)  Primary  Billing

**Comments:** \_\_\_\_\_

**Provider Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**- OPTIMA USE ONLY -**

**Action Requested:**

- \_\_\_ Address Change: New Billing Office Address/Ph/Fax
- \_\_\_ Address Change: New Primary Address/Ph/Fax
- \_\_\_ Additional Office Location
- \_\_\_ Set up **new** provider & **new** vendor
- \_\_\_ Add **new** provider to **existing** vendor
- \_\_\_ Change **existing** provider from one vendor to another **existing** vendor
- \_\_\_ Change **existing** provider from existing vendor to **new** vendor
- \_\_\_ Change provider/vendor name
- \_\_\_ Change specialty on existing provider
- \_\_\_ Add existing provider to new product
- \_\_\_ Change vendor reimbursement
- \_\_\_ Email: Provider/Vendor \_\_\_\_\_ Other \_\_\_\_\_

**Effective Date:**  
\_\_\_\_\_

**Voluntary Termination:**

- \_\_\_ contracting failure
- \_\_\_ provider dissatisfaction with plan participation
- \_\_\_ exclusive alignment with competition
- \_\_\_ unwilling to give reason/unknown
- \_\_\_ SHP initiated for habitual non-compliance

**Involuntary Termination:**

- \_\_\_ relocated to non-par practice in-network area
- \_\_\_ quality of care/service term by SHP
- \_\_\_ retired
- \_\_\_ disabled/ill
- \_\_\_ deceased
- \_\_\_ out-of-network area relocation
- \_\_\_ non-compliance with recertifying requirements

**Other Changes:**

- \_\_\_ in area relocation – changing par practices
- \_\_\_ termination of LOB
- \_\_\_ specialty changed
- \_\_\_ other

Comments: \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

Please fax to:  
 757-552-7114 - Hampton Roads/NC  
 804-510-7459 - Richmond/Western VA

**MEMBER MATCHING INFORMATION**

*This information will appear on your provider profile on [www.optimabehavioralhealth.com](http://www.optimabehavioralhealth.com). Please complete entirely; any omitted information will be blank on the website and may exclude you from a member's "Find a Provider" search.*

**Provider Name:** \_\_\_\_\_ **NPI:** \_\_\_\_\_ **Tax ID:** \_\_\_\_\_

**Office Hours:** *These hours should be inclusive of your availability at all locations you may have with this practice tax ID.*

Office Hours	Start	End		Start	End
Monday				Friday	
Tuesday				Saturday	
Wednesday				Sunday	
Thursday					

**1. Office Accessibility**

- Wheelchair Accessible       Use of TDD       Public Transportation within one block

**2. Populations Seen**

- Younger Children (0-5 years)       Women       Gay / Lesbian       Philippine  
 Older Children (6-12 years)       Family       In-Patient       Child/Adolescent  
 Adolescents (13-18 years)       Couples       Korean       Training/Fellowship  
 Adults       Geriatric       Hispanic       Child/Adolescent  
 Men       Step Families       Vietnamese       Board Certified MD

**3. Treatment Categories – (please check all that apply)**

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Addictions                | <input type="checkbox"/> ECT-Outpatient             | <input type="checkbox"/> Outpatient Treatment            |
| <input type="checkbox"/> ADHD                      | <input type="checkbox"/> Family/Victim Violence     | <input type="checkbox"/> Phobias/Habit Disorders         |
| <input type="checkbox"/> Anger Management          | <input type="checkbox"/> Forensic Evaluation        | <input type="checkbox"/> Physically Impaired             |
| <input type="checkbox"/> Anxiety Disorders         | <input type="checkbox"/> Grief                      | <input type="checkbox"/> Psychological Testing           |
| <input type="checkbox"/> Autism Spectrum Disorders | <input type="checkbox"/> Head Injury Patients       | <input type="checkbox"/> PTSD                            |
| <input type="checkbox"/> Bipolar Disorder          | <input type="checkbox"/> Hearing Impaired           | <input type="checkbox"/> Separation/Divorce              |
| <input type="checkbox"/> Blind/Visually Impaired   | <input type="checkbox"/> HIV/AIDS                   | <input type="checkbox"/> Sexual Disorders                |
| <input type="checkbox"/> Christian Focus           | <input type="checkbox"/> Hypnosis                   | <input type="checkbox"/> Sexual/Physical Abuse           |
| <input type="checkbox"/> Chronic Pain              | <input type="checkbox"/> Inpatient Treatment        | <input type="checkbox"/> Substance Abuse                 |
| <input type="checkbox"/> Crisis Intervention       | <input type="checkbox"/> Intellectually Disabled    | <input type="checkbox"/> Terminally Ill                  |
| <input type="checkbox"/> Depression                | <input type="checkbox"/> Medication Management      | <input type="checkbox"/> <b>Therapy - Family</b>         |
| <input type="checkbox"/> Development Disability    | <input type="checkbox"/> Mood Disorders             | <input type="checkbox"/> <b>Therapy - Group</b>          |
| <input type="checkbox"/> Eating Disorders          | <input type="checkbox"/> Neuropsychological Testing | <input type="checkbox"/> <b>Therapy – Individual</b>     |
| <input type="checkbox"/> ECT-Inpatient             |   | <input type="checkbox"/> <b>Therapy – Marital/Couple</b> |

**4. Foreign Languages**

Language \_\_\_\_\_ Language \_\_\_\_\_ Language \_\_\_\_\_

**5. Additional Provider Information** *(It is our experience that patients often express preferences for providers of a particular ethnic background or gender. Providing this information will include you in the search list for these categories on [www.optimabehavioralhealth.com](http://www.optimabehavioralhealth.com).)*

**Gender**

- Male  
 Female

**Ethnicity**

- African-American       Caucasian  
 American Indian/Alaska Native       Hispanic  
 Asian       Other \_\_\_\_\_