BEHAVIORAL HEALTH SERVICES

Billing Company/Consultant Registration/Notification Form

Provider/Facility

Name: ____

Address: ____

City: ______________________________________ State: __________ Zip: _______

Telephone: ___________________________Tax ID No: _________________________

Contact Person: ____

Contracted Billing Company/Consultant: ____

Contract Effective Date: _________________________ End Date: __________________

Address: ____

City: ______________________________________ State: __________ Zip: _______

Telephone: ___________________________Tax ID No: _________________________

Contact Person: ____

Date Business Associate Agreement Signed: ____________________________________

Copy of Business Associate Agreement or signed attestation must be submitted with this form.

By submitting this request form, I hereby agree to notify Optima Health Plan immediately upon the termination of the Agreement with the above named billing company/consultant.

Date: _______________________ By: ______________________________

Fax Form To: or Mail Form To:

OBH Provider Services
(757) 552-7114

OBH Provider Services
4417 Corporation Lane
Virginia Beach, VA 23462