

*Provider # _____
(Optima use only)

OPTIMA BEHAVIORAL HEALTH Provider Update Form

Please fax to: 757-552-7114

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 Provider Email: _____

Practice: Name: _____ *Vendor # _____
(Optima use only)

Tax ID _____ Group NPI _____

Practice Manager: _____ 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 Tax ID on existing provider/vendor
- ___ Change provider/vendor name
- ___ Change specialty on existing provider
- ___ Add existing provider to new network
- ___ Change provider's reimbursement
- ___ Email: Provider/Vendor

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 recredentialing requirements

Other Changes:

- ___ in area relocation – changing par practices
- ___ termination of LOB
- ___ specialty changed
- ___ Lock out all LOBs
- ___ Non Par all LOBs

Comments: _____

Signature _____ Date _____

MEMBER MATCHING INFORMATION

Optima Behavioral Health uses this information to refer our members to providers who meet their specific needs.
To maximize your referrals, it is important to check each category that applies.

Provider Name: _____ **NPI** _____ **Tax ID** _____

1. Office Hours

Monday _____ Tuesday _____ Wednesday _____ Thursday _____
Friday _____ Saturday _____ Sunday _____

2. Office Accessibility

- Wheelchair Accessible Use of TDD Public Transportation within one block

3. Populations Seen

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

4. Treatment Categories (please check all that apply)

- | | | |
|--|---|--|
| <input type="checkbox"/> Psychotherapy - Couple | <input type="checkbox"/> Development Disability | <input type="checkbox"/> Job Stress |
| <input type="checkbox"/> Psychotherapy - Family | <input type="checkbox"/> EAP Services | <input type="checkbox"/> Mood Disorder |
| <input type="checkbox"/> Psychotherapy - Group | <input type="checkbox"/> EAP CISM Trained | <input type="checkbox"/> Neuropsychological Assessment |
| <input type="checkbox"/> Psychotherapy - Individual | <input type="checkbox"/> EAP SAP Trained | <input type="checkbox"/> Organic Brain |
| <input type="checkbox"/> Addictions | <input type="checkbox"/> Eating Disorders | <input type="checkbox"/> Outpatient Traditional Practice for Mental Health |
| <input type="checkbox"/> ADHD | <input type="checkbox"/> ECT-Inpatient | <input type="checkbox"/> Parenting |
| <input type="checkbox"/> Anger Management | <input type="checkbox"/> ECT-Outpatient | <input type="checkbox"/> Pharmacotherapy |
| <input type="checkbox"/> Anxiety Disorder | <input type="checkbox"/> Evaluation & Referral: Mental Health | <input type="checkbox"/> Phobias/Habit Disorders |
| <input type="checkbox"/> Behavior Modification | <input type="checkbox"/> Evaluation & Referral: Substance Abuse | <input type="checkbox"/> Physically Impaired |
| <input type="checkbox"/> Biofeedback | <input type="checkbox"/> Family System | <input type="checkbox"/> Psychoanalytic/Psychodynamic |
| <input type="checkbox"/> Blind/Visually Impaired | <input type="checkbox"/> Family/Victim Violence | <input type="checkbox"/> Psychological Testing |
| <input type="checkbox"/> Brief Treatment: Mental Health | <input type="checkbox"/> Forensic Evaluation | <input type="checkbox"/> Psychosomatic/Somatoform |
| <input type="checkbox"/> Brief Treatment: Substance Abuse | <input type="checkbox"/> Grief | <input type="checkbox"/> Psychotic Disorder |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Head Injury Patients | <input type="checkbox"/> PTSD |
| <input type="checkbox"/> Child/Adolescent | <input type="checkbox"/> Hearing Impaired | <input type="checkbox"/> Separation/Divorce |
| <input type="checkbox"/> Christian Focus | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Sexual Disorders |
| <input type="checkbox"/> Chronic Pain | <input type="checkbox"/> Hypnosis | <input type="checkbox"/> Sexual/Physical Abuse |
| <input type="checkbox"/> Cognitive-Behavioral | <input type="checkbox"/> Inpatient Psychiatry | <input type="checkbox"/> Substance Abuse |
| <input type="checkbox"/> Crisis Intervention | <input type="checkbox"/> Intellectually Disabled | <input type="checkbox"/> Terminally I |
| <input type="checkbox"/> Depression | | |

5. Foreign Languages

Language _____ Language _____ Language _____

Optional Provider Information *(It is our experience that patients often express preferences for providers of a particular ethnic background or gender, and employers may wish to determine if our network reflects the ethnic/gender profile of their employees. If you wish to volunteer to provide the following information, it will be held in strictest confidence and will be used only when a patient indicates such information is important in selecting a provider. This information will not be released to any other party, except in aggregate form.)*

Gender

- Male
 Female

Ethnic Background

- | | |
|-------------------------------------|--------------------|
| _____ African-American | _____ Caucasian |
| _____ American Indian/Alaska Native | _____ Hispanic |
| _____ Asian | _____ Multi-Racial |
| | _____ Other _____ |