*Provider # _____ (Optima use only)

*Priority ☐

OPTIMA BEHAVIORAL HEALTH
Provider Update Form

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

Change Requested:

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

Effective Date: _____

Provider: Name _____ SS# _____

NPI _____ Taxonomy: _____ *Specialty Code: _____

License Type: _____ VA License#: _____ Degree _____

VA MCD# _____ MCR# _____ DEA# (if applicable) _____

Board Status: ☐Cert ☐Not Cert ☐Elig ☐Grandfathered ☐Undersv **Provider Email:** _____

Practice: Name _____ *Vendor # _____

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 X Billing

Comments: _____

Provider Signature _____ Date _____

Action Requested: **- OPTIMA USE ONLY -**

___ 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 one vendor to **new** vendor and **remove old ALOCs**

___ 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 recredentialing requirements

Other Changes:
___ in area relocation – changing par practices
___ termination of LOB
___ specialty changed
___ other

Comments: _____

Signature _____ Date _____

MEMBER MATCHING INFORMATION

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

This information will appear on your provider profile on 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 Accesibility

☐ Wheelchair Accessible ☐ Use of TDD ☐ Public Transportation within one block

2. Populations Seen

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

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

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

4. Foreign Languages

Language _____ Language _____ Language _____

5. Other 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*

Gender

☐ Male
☐ Female

Ethnicity

☐ African-American
☐ American Indian/Alaska Native
☐ Asian
☐ Caucasian
☐ Hispanic
☐ Other _____