*Provider # _____ (Optima use only)

*Priority ☐

OPTIMA HEALTH
Provider Update Form

Please fax to:
757-552-7114 - Hampton Roads/NC
804-510-7459 - Richmond/Northern VA
540-562-8222 - Western/Far Southwest 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

Network Educator: _____

Comments: _____

Signature _____ Date _____

MEMBER MATCHING INFORMATION

Please fax to:
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This information will appear on your provider profile. 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:** _____

1. 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					

2. Office Accessibility:

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

3. Languages Spoken in the office:

☐ English ☐ Vietnamese ☐ Portuguese ☐ Yupik
☐ Spanish ☐ Korean ☐ Italian ☐ Polish
☐ German ☐ Navajo ☐ Arabic ☐ French Creole
☐ French ☐ Tagalog ☐ Dakota ☐ Other: _____

***4.* Gender and Ethnicity:** *(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 our website.)*

Gender:
☐ Male
☐ Female

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

5. Cultural Competency Attestation

Has this provider complete Cultural Competency Training? ☐ Yes ☐ No

6. Populations Seen *(Behavioral Health only)*

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

7. Treatment Categories *(Behavioral Health only, please check all that apply)*

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