

*Provider # _____
(Optima use only)

**OPTIMA BEHAVIORAL HEALTH
Provider Update Form**

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

*Priority

Change Requested:

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> Changing Practice | <input type="checkbox"/> Physical Address | <input type="checkbox"/> Tax ID (W9 form required) | <input type="checkbox"/> Add/Change Provider Email |
| <input type="checkbox"/> Additional Practice | <input type="checkbox"/> Billing Address | <input type="checkbox"/> Name Change | <input type="checkbox"/> Add/Change Practice Email |
| <input type="checkbox"/> Additional Location (for current practice) | <input type="checkbox"/> Telephone/Fax | <input type="checkbox"/> Leaving Practice | <input type="checkbox"/> 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 Billing

Comments: _____

Provider Signature _____ **Date** _____

<p>Action Requested:</p> <p><input type="checkbox"/> Address Change: New Billing Office Address/Ph/Fax</p> <p><input type="checkbox"/> Address Change: New Primary Address/Ph/Fax</p> <p><input type="checkbox"/> Additional Office Location</p> <p><input type="checkbox"/> Set up new provider & new vendor</p> <p><input type="checkbox"/> Add new provider to existing vendor</p> <p><input type="checkbox"/> Change existing provider from one vendor to another existing vendor</p> <p><input type="checkbox"/> Change existing provider from one vendor to new vendor and remove old ALOCs</p> <p><input type="checkbox"/> Change provider/vendor name</p> <p><input type="checkbox"/> Change specialty on existing provider</p> <p><input type="checkbox"/> Add existing provider to new product</p> <p><input type="checkbox"/> Change vendor reimbursement</p> <p><input type="checkbox"/> Email: Provider/Vendor _____ Other _____</p> <p>Comments: _____</p> <p>Signature _____ Date _____</p>	<p>- OPTIMA USE ONLY -</p> <div style="border: 2px solid black; padding: 5px; width: fit-content; margin: 0 auto;"> <p>Effective Date: _____</p> </div>	<p>Voluntary Termination:</p> <p><input type="checkbox"/> contracting failure</p> <p><input type="checkbox"/> provider dissatisfaction with plan participation</p> <p><input type="checkbox"/> exclusive alignment with competition</p> <p><input type="checkbox"/> unwilling to give reason/unknown</p> <p><input type="checkbox"/> SHP initiated for habitual non-compliance</p> <p>Involuntary Termination:</p> <p><input type="checkbox"/> relocated to non-par practice in-network area</p> <p><input type="checkbox"/> quality of care/service term by SHP</p> <p><input type="checkbox"/> retired</p> <p><input type="checkbox"/> disabled/ill</p> <p><input type="checkbox"/> deceased</p> <p><input type="checkbox"/> out-of-network area relocation</p> <p><input type="checkbox"/> non-compliance with recertification requirements</p> <p>Other Changes:</p> <p><input type="checkbox"/> in area relocation – changing par practices</p> <p><input type="checkbox"/> termination of LOB</p> <p><input type="checkbox"/> specialty changed</p> <p><input type="checkbox"/> other</p>
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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 Accessibility

- Wheelchair Accessible
 Use of TDD
 Public Transportation within one block

2. Populations Seen

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> Younger Children (0-5 years) | <input type="checkbox"/> Women | <input type="checkbox"/> Gay / Lesbian | <input type="checkbox"/> Phillipine |
| <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 | 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 | 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"/> Therapy - Family |
| <input type="checkbox"/> Development Disability | <input type="checkbox"/> Mood Disorders | <input type="checkbox"/> Therapy - Group |
| <input type="checkbox"/> Eating Disorders | <input type="checkbox"/> Neuropsychological Testing | <input type="checkbox"/> Therapy - Individual |
| <input type="checkbox"/> ECT-Inpatient | | <input type="checkbox"/> 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

- | | |
|--|--------------------------------------|
| <input type="checkbox"/> African-American | <input type="checkbox"/> Caucasian |
| <input type="checkbox"/> American Indian/Alaska Native | <input type="checkbox"/> Hispanic |
| <input type="checkbox"/> Asian | <input type="checkbox"/> Other _____ |