

*Provider # _____
(Optima use only)

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

*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** _____

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

- | | | | |
|----------------------------------|-------------------------------------|-------------------------------------|--|
| <input type="checkbox"/> English | <input type="checkbox"/> Vietnamese | <input type="checkbox"/> Portuguese | <input type="checkbox"/> Yupik |
| <input type="checkbox"/> Spanish | <input type="checkbox"/> Korean | <input type="checkbox"/> Italian | <input type="checkbox"/> Polish |
| <input type="checkbox"/> German | <input type="checkbox"/> Navajo | <input type="checkbox"/> Arabic | <input type="checkbox"/> French Creole |
| <input type="checkbox"/> French | <input type="checkbox"/> Tagalog | <input type="checkbox"/> Dakota | <input type="checkbox"/> 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)*

- | | | | |
|---|--|--|---|
| <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 Training/Fellowship |
| <input type="checkbox"/> Adolescents (13-18 years) | <input type="checkbox"/> Couples | <input type="checkbox"/> Korean | <input type="checkbox"/> Child/Adolescent Board Certified MD |
| <input type="checkbox"/> Adults | <input type="checkbox"/> Geriatric | <input type="checkbox"/> Hispanic | |
| <input type="checkbox"/> Men | <input type="checkbox"/> Step Families | <input type="checkbox"/> Vietnamese | |

7. Treatment Categories *(Behavioral Health only, 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 |