MENTAL HEALTH PLAN FEE-FOR-SERVICE PROVIDER UPDATE FORM

Purpose:
This form is to be used by Mental Health Plan Fee-for-Service (MHP FFS) individual and group providers. Complete and submit this form to the Network Office when the following changes occur:

- Location/Address
- Email, phone, and/or fax number
- Name
- Status with any licensing/oversight board that may impact your ability to provide, claim, or be reimbursed for specialty mental health services.

Instructions:

1. Complete and email this form to procurement@acgov.org *Subject: MHP FFS Provider Update*
2. For changes in availability (dates, times, and client slots), please call ACCESS at (800) 491-9099 or email accessdesk@acgov.org *Subject: MHP FFS Provider Availability Update*.

☐ **Individual Provider/Practitioner**	Last Name		First Name		Middle Initial	
☐ **Group or Organization**	Group/ Organization Name		Contact Person Last Name		Contact Person First Name	
	Contact Person Phone Number		Contact Person Email		Effective Date for Update(s)	

Reason for Update *check all that apply*	**Current**				**New**			
☐ **Change of Practice Location/Address** *(use this when moving from one location to another)*	Street Address		City, State & ZIP		Street Address ☐ ♿		City, State & ZIP	
	Phone		Fax		Phone		Fax	
☐ **Addition of New Practice Location/Address** *(use this when adding another practice location in addition to the current practice location)* ☐ **Removal of Existing Practice Location/Address** *(use this when no longer at a location)*					Street Address ☐ ♿		City, State & ZIP	
					Phone		Fax	

♿ Denotes ADA Accessibility

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Group/ Organization Name		Last Name		First Name	

Reason for Update *check all that apply*	**Current**				**New**			
☐ **Change of Mailing Address**	Street Address		City, State & ZIP		Street Address		City, State & ZIP	
	Phone		Fax		Phone		Fax	
☐ **Change of Billing Address**	Street Address		City, State & ZIP		Street Address		City, State & ZIP	
	Phone		Fax		Phone		Fax	
☐ **Change of Tax ID Address** *Complete and submit a new W-9)*	Street Address		City, State & ZIP		Street Address		City, State & ZIP	
	Phone		Fax		Phone		Fax	
☐ **Change of Email**	**Current**				**New**			
☐ **Change of Phone Number**	**Current**				**New**			
☐ **Change of Fax Number**	**Current**				**New**			
☐ **Change of Name**	**Current**				**New**			
☐ **Change of Tax ID Number**	**Current**				**New**			
☐ **Change of status with any licensing/oversight board that may impact your ability to provide, claim, or be reimbursed for specialty mental health services**								
Describe the change and include the licensing/oversight board								

Complete and submit this form to the Network Office:

Alameda County Behavioral Health Care Services - Network Office
1900 Embarcadero Cove, Suite 205
Oakland, CA 94606
procurement@acgov.org or Fax (510) 567-8290