**MENTAL HEALTH PLAN FEE-FOR-SERVICE PROVIDER UPDATE FORM**

**Purpose:**

This form is to be used by individual and group providers/practitioners who are currently contracted with BHCS to provide services for the Fee-for-Service Mental Health Plan. 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](mailto:procurement@acgov.org) *Subject: MHP Provider Update*

2. For changes in availability (dates, times, and client slots), please call ACCESS at (800) 491-9099   
or email [accessdesk@acgov.org](mailto:accessdesk@acgov.org) *Subject: MHP Provider Network 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 |  |

**MENTAL HEALTH PLAN FEE-FOR-SERVICE PROVIDER UPDATE FORM**

| 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** | 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](mailto:procurement@acgov.org) or Fax (510) 567-8290

Applications & Templates\Provider Update Form 110117