**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 *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 *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 |       |
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| **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 or Fax (510) 567-8290

Applications & Templates\Provider Update Form 110117