



# Agency / Community Mental Health Center / Clinic Clinician Roster Update Form

Throughout this document, the term "Agency" is used to refer to Agencies, Community Mental Health Centers, and Clinics.

To ensure proper maintenance of your <u>independently licensed</u> clinician roster, complete and submit this form as staffing changes occur. Form may also be used to confirm that no changes to the roster are required at this time. Non-licensed staff should not be included on this report. Only include independently licensed staff who will submit claims. To ensure clarity, please complete this form electronically rather than in handwriting, if possible. Multiple forms can be submitted, if necessary.

#### Section A: Agency Information / Update Type

Name of Agency: Update Type:

Add, delete or update Clinician data
 Confirm that NO CHANGES are required to Clinician data

Tax Identification Number (TIN):

All changes listed on this form must correspond to the TIN shown above. If the Agency has more than one TIN, please submit a separate form for each TIN.

#### Section B: Deletions List all independently licensed clinicians who have left the Agency

| Last Name | First Name | Individual NPI | Effective Date of<br>Deletion |
|-----------|------------|----------------|-------------------------------|
|           |            |                |                               |
|           |            |                |                               |
|           |            |                |                               |
|           |            |                |                               |
|           |            |                |                               |
|           |            |                |                               |
|           |            |                |                               |

#### Section C: Additions / Updates

Check here if new clinician(s) is being added or if existing clinician data requires updating. Complete a copy of page 2 for each clinician being added or updated.

#### Section D: Acknowledgement by Administrator / Roster Contact

| Roster Contact (printed name)        | Signature (or email address)                      | Date              |
|--------------------------------------|---|-------------------|
| Fax or email completed form to Optum | /OptumHealth Behavioral Solutions of California N | etwork Management |
| Conta                                | ct information at providerexpress.com             |                   |

### Agency / Community Mental Health Center / Clinic – Clinician Roster Update Form

Section C (continued): Complete one page for each new or updated independently licensed clinician

| <ul> <li>Add new clinician</li> <li>Update existing clinician data</li> <li>Effective Date of</li> </ul> |      |       |                       |                         |                                      |                       |                     |                                       | -   |     |
|--|------|-------|-----------------------|-------------------------|--------------------------------------|-----------------------|---------------------|---------------------------------------|---|-----|
| Last Name:<br>First Name:<br>Middle Initial:   |      |       |                       |                         | Individual NPI:<br>Taxonomy:<br>SSN: |                       |                     |                                       |   |     |
| License Level (MD, LP, LCSW, APRN, etc.):  |      |       |                       | Date o                  | f Rirth                              |                       |                     |                                       |   |     |
| License Level (MD, LP, LCSW, APRN, etc.).  |      |       |                       | Individual Medicare ID: |                                      |                       |                     |                                       |   |     |
|  |      |       | ive Authority?        | ☐ Yes                   | □ No                                 | Medicare Issue Date:  |                     |                                       |   |     |
|  | Gen  | •     | ive / tutionty :      | ☐ Male                  |                                      | Individ               | ual Medica          |                                       |   |     |
|  | Con  | uon.  |                       |                         |                                      | Medicaid Issue State: |                     |                                       |   |     |
|  |      |       |                       |                         |                                      |                       |                     | d Issue Date:                         |   |     |
|  | Prim | arv   | Practice Location (ca | annot contain           | a PO Box):                           |                       | mouloui             |                                       |   |     |
|  |      | -     | Practice Address      |                         | City                                 | State                 | Zip                 | Site Conditions                       | Availability                                      |     |
|  |      |       |                       |                         |                                      |                       | •                   | Evening Apps                          | Inpatient or In-Home Or<br>Accepting New Patients |     |
| Phone  |      |       |                       | Secure Fax              |                                      | o Secure              | Public Trans Access |                                       |   |     |
| Additional Practice Location(s) (cannot conta  |      |       | al Practice Location  |                         |                                      |                       |                     |                                       |   |     |
|  | Add  | elete | Practice Address      |                         | City                                 | State                 | Zip                 | Site Conditions                       | Availability                                      |     |
| 1  |      |       |                       |                         |                                      |                       |                     | Evening Apps                          | Inpatient or In-Home Or                           | ιlv |
| <u> </u>   |      |       | Dhana                 |                         | Secure Fax                           |                       |                     | - Weekend Appts                       | Accepting New Patients                            |     |
|  |      |       | Phone                 |                         | Secure Fax                           |                       | Secure              | Public Trans Access                   |   |     |
|  |      |       |                       |                         |                                      | Fa                    | X                   | Wheelchair Access                     |   |     |
| 2  |      |       |                       |                         |                                      |                       |                     | Evening Apps                          | Inpatient or In-Home Or                           |     |
|  |      |       | Phone                 |                         | Secure Fax                           |                       | Secure              | - Weekend Appts                       | Accepting New Patients                            |     |
|  |      |       |                       |                         |                                      | Fa                    |                     | Wheelchair Access                     |   | _   |
| 3  |      |       |                       |                         |                                      |                       |                     | Evening Apps                          | Inpatient or In-Home Or                           |     |
|  |      |       | Phone                 |                         | Secure Fax                           |                       | 0                   | Weekend Appts                         | Accepting New Patients                            | i   |
|  |      |       |                       |                         |                                      | ——— ∐ No<br>Fa        | o Secure            | Public Trans Access Wheelchair Access |   |     |

## Agency / Community Mental Health Center / Clinic – Clinician Roster Update Form (Additional page 2, if needed)

Section C (continued): Complete one page for each new or updated independently licensed clinician

|  |     |            | d new clinician<br>date existing clinicia | n data  | Effective Date of Effective Date of Effective Date of the sector of the |  |               |   |   |  |
|--|-----|------------|---|---|---|--|---------------|---|---|--|
| Last Name:<br>First Name:<br>Middle Initial: |     |            |   |   | Individual NPI:<br>Taxonomy:<br>SSN:  |  |               |   |   |  |
| License Level (MD, LP, LCSW, APRN, etc.):    |     |            | :   | Date of Birth:  |   |  |               |   |   |  |
| Prescriptive Authority?  Yes Gender:  Male   |     |            |   | Male  | No<br>Female  | Medicaid ID:<br>Individual Medicaid ID:<br>Medicaid Issue State:<br>Medicaid Issue Date: |               |   |   |  |
|  |     | -          | Practice Location (<br>Practice Address   | cannot contair  | City  | State  | Zip           | Site Conditions   | Availability  |  |
| Phone  |     | Secure Fax |   | Image: Strain of the strain |   | <ul> <li>Inpatient or In-Home Only</li> <li>Accepting New Patients</li> </ul>            |               |   |   |  |
|  | ddi | lete       | al Practice Location<br>Practice Address  | n(s) (cannot co   | ontain a PO Box):   | State  | Zip           | Site Conditions   | Availability  |  |
| 1 [  |     |            | Phone                                     |   | Secure Fax  | D No<br>Fa   | o Secure<br>x | Evening Apps     Weekend Appts     Public Trans Access     Wheelchair Access                                    | <ul> <li>Inpatient or In-Home Only</li> <li>Accepting New Patients</li> </ul> |  |
| 2 [  |     |            | Phone                                     |   | Secure Fax  | No Fa  | o Secure<br>x | Evening Apps     Weekend Appts     Public Trans Access     Wheelchair Access                                    | Inpatient or In-Home Only Accepting New Patients                              |  |
| 3 [  |     |            | Phone                                     |   | Secure Fax  | 🗌 No<br>Fa   | o Secure<br>x | <ul> <li>Evening Apps</li> <li>Weekend Appts</li> <li>Public Trans Access</li> <li>Wheelchair Access</li> </ul> | Inpatient or In-Home Only Accepting New Patients                              |  |