

Provider Change Request Form

Submit completed form and all applicable attachments to CredentialingTeam@PartnersBHM.org.

Date of Request: _____

Provider Information
Provider type: ☐ Agency ☐ Independently Contracted Licensed Independent Practitioner (LIP)
Legal Name of Organization/LIP Practice:
Federal Tax ID/Social Security Number:

Contact Information (for this request)			
Name:		Title:	
Email:		Phone:	
Contract Signer Name:		Contract Signer Email:	
Mailing Address:			
	Street		City
	State	Zip	County

Check the change(s) requested below	Complete	Supporting Documents Required?
☐ Add/Remove Site	Section A	No
☐ Add/Remove Service(s)	Section B	No
☐ Update Services Site Panel limits	Section C	No
☐ Add/Update Professional License/Certification, Practitioner Name Change	Section D	Yes
☐ Add/Remove Practitioner or Initiate Enrollment of a Practitioner	Section E	Yes
☐ Change Contact Information/Address	Section F	No
☐ Change NPI/Taxonomy Number	Section G	No
☐ LIP to Agency/Agency to LIP contract change	Section H	Yes
☐ Other Changes	Section I	No

Signature and Attestation

By signing below, I hereby certify that all of the information and attachments provided herein are true and accurate to the best of my knowledge. I further understand that any false or misleading information may be cause for denial or termination of any and all agreements with Partners. Submission of this request does not guarantee approval.

I further signify my willingness for Partners to verify all information presented in this request and to provide additional information, if needed, to verify accuracy of the information contained therein. I agree to provide any additional information upon request to verify information and address issues of concern during the processing of this request. I also consent for the Partners to interview any individuals that may have information related to this request or the qualification(s) related to the applicant/organization. I understand that I have the right to review and correct information to support my application and to request the status of my application at any time.

Finally, I attest that I am not aware of any conflict of interest existing between Partners and the Applicant.

Legally Authorized Representative Name**Title****Date**

Section A – Add/Remove Site			
☐ Site to be REMOVED		Requested Effective Date:	
Service Site Name:			
Site NPI:			
Physical Address:			
	Street		City
	State	Zip + 4	County

☐ Site to be ADDED		Requested Effective Date:	
Please complete ENTIRE SECTION for EACH site you would like to add.			
Site Specific Information – A service site is a physical location where records are maintained and/or supervision and/or management of services occur. Authorizations and billing are tied to these sites. All sites MUST be enrolled in NC Tracks prior to enrollment, authorizations or billing through the MCO. Please note: Level I, and Level II TFC, Family Living (AFL) and Independent Living providers do NOT need to submit Section III for each private home where these services are provided. Instead, those services should be included at the provider site where those services are managed.			
Service Site Name:			
Site NPI:		Phone:	Fax:
Physical Address:			
	Street		City
	State	Zip	County
Site Contact Person:			
Site Contact Person Email:			

Enhanced and Alternative Services Provided at this Site (Most of these services require national accreditation):	NPI	Taxonomy
☐ Ambulatory Detoxification – License Required		
☐ Assertive Community Treatment Team (ACTT)		
☐ Behavioral Health Urgent Care (BHUC)		
☐ Community Support Team (CST)		
☐ Critical Time Intervention (CTI)		
☐ Day Treatment Child/Adolescent – License Required		
☐ Diagnostic Assessment (Enhanced T1023)		
☐ Diversion and Assessment Program (DAP) – PRTF License Required		
☐ Facility Based Crisis – License Required		
☐ Family Centered Treatment (FCT) (must be approved provider): www.familycenteredtreatment.com/current-providers		
☐ Intensive Alternative Family Treatment (IAFT) (must be approved provider): http://ncrapidresource.org/NetworkMembers.aspx		
☐ Intensive In-Home		
☐ Intermediate Care Facility (ICF/IID) – License Required		
☐ Long Term Community Supports		
☐ Medically Supervised or ADATC Detoxification/Crisis Stabilization – License Required		
☐ Mobile Crisis Management		
☐ Multi Systemic Therapy (MST) (must be approved provider): https://www.mstservices.com/our-community		
☐ Non-Hospital Medical Detox – License Required		
☐ Outpatient Opioid Treatment – License Required		
☐ Partial Hospitalization – License Required		
☐ Peer Support		
☐ Psychiatric Residential Treatment Facility (PRTF) – License Required		
☐ Psychosocial Rehabilitation (PSR) – License Required		
☐ Residential Treatment Level I/Family Type		
☐ Residential Treatment Level II/Family Type (TFC)		

☐ Residential Treatment Level II/Group – License Required		
☐ Residential Treatment Level III – License Required		
☐ Residential Treatment Level IV – Licensed Required		
☐ SA Comprehensive Outpatient Treatment Program (SACOT) – License Required		
☐ SA Intensive Outpatient Program (SAIOP) – License Required		
☐ SA Medically Monitored Residential Treatment – License Required		
☐ SA Non-Medical Community Residential Treatment – License Required		
☐ Targeted Case Management		

1915(i) Services (These services require national accreditation):	NPI	Taxonomy
☐ Community Living and Supports		
☐ Community Transition		
☐ Individual and Transitional Supports		
☐ Individual Placement and Supports (fidelity review required)		
☐ Respite – License required for private home respite with two or more individuals living in the home and facility respite		
☐ Supported Employment for I/DD and TBI		

Innovations Services Provided at this Site (These services require national accreditation):	NPI	Taxonomy
☐ Community Living & Supports		
☐ Community Navigator*		
☐ Community Networking		
☐ Community Transition Supports* (must also provide community navigator)		
☐ Crisis Services		
☐ Day Supports – License Required		
☐ Natural Supports Education		
☐ Residential Supports – License may be required		

☐ Respite Services – License required for private home respite with two or more individuals living in the home and facility respite		
☐ Specialized Consultative Services		
☐ Supported Employment Services		
☐ Supported Living		
☐ Other (specify):		

State Services Provided at this Site:		
Do you have an IPRS contract with Partners? ☐ Yes ☐ No If not, contact your assigned Provider Network Account Specialist (http://providers.partnersbhm.org/find-provider-specialist/) .	NPI	Taxonomy
☐ Adult Day Vocational Program (ADVP) – License Required		
☐ Ambulatory Detox – License Required		
☐ Assertive Community Treatment Team		
☐ Community Based Rehabilitation Program		
☐ Community Support Team		
☐ Day Activity – License Required		
☐ Day Supports		
☐ Developmental Day – License Required		
☐ Developmental Therapy		
☐ Diagnostic Assessment		
☐ Facility Based Crisis – License Required		
☐ Family Living		
☐ Group Living – License Required		
☐ Hospital Discharge Transition		
☐ Independent Living		
☐ Intensive Alternative Family Treatment (IAFT) (must be approved provider): http://ncrapidresource.org/NetworkMembers.aspx		
☐ Long-Term Support		
☐ Mobile Crisis Management		

☐ Multi Systemic Therapy (MST) (must be approved provider): https://www.mstservices.com/our-community		
☐ Non-Hospital Medical Detox – License Required		
☐ Outpatient Opioid Treatment – License Required		
☐ Partial Hospitalization – License Required		
☐ Peer Support		
☐ Personal Assistance		
☐ Psychiatric Residential Treatment Facility (PRTF) – License Required		
☐ Psychosocial Rehabilitation – License Required		
☐ Residential Treatment Level I/Family Type		
☐ Residential Treatment Level II/Family Type (TFC)		
☐ Residential Treatment Level II/Group – License Required		
☐ Residential Treatment Level III – License Required		
☐ Residential Treatment Level IV – Licensed Required		
☐ Respite – License required for private home respite w/two or more individuals living in the home and facility respite		
☐ SA Comprehensive Outpatient Treatment Program (SACOT) – License Required		
☐ SA Intensive Outpatient Program (SAIOP) – License Required		
☐ SA Non-Medical Community Residential Treatment – License Required		
☐ Supervised Living		
☐ Supported Employment		
☐ Transition Management Services		

Outpatient Services	
a. Adult Outpatient Services (Taxonomy associated with Adult Outpatient Services)	
☐ Check here if you do NOT provide Adult Outpatient Services at this location	☐ Check here if you provide Telepsychiatry Services at this site.
☐ Adult ABA Services	
☐ Adult IID Medication Management	
☐ Adult IID Outpatient	
☐ Adult IID Psychological Testing	
☐ Adult MH Medication Management	
☐ Adult MH Outpatient	
☐ Adult MH Psychological Testing	
☐ Adult SA Medication Management	
☐ Adult SA Outpatient	

b. Child Outpatient Services (Taxonomy associated with Child Outpatient Services)
☐ Check here if you do NOT provide Child Outpatient Services at this location
☐ Adult ABA Services
☐ Child IID Medication Management
☐ Child IID Outpatient
☐ Child IID Psychological Testing
☐ Child MH Medication Management
☐ Child MH Outpatient
☐ Child MH Psychological Testing
☐ Child RB-BHT Services
☐ Child SA Medication Management
☐ Child SA Outpatient
Other services not listed above:

Section B – Add/Remove Services

Requested Effective Date:

Service Site Physical
Address:

Street

City

State

Zip + 4

County

☐ **Services to be ADDED**Is the organization nationally accredited? ☐ Yes ☐ No ☐ Not Required

If yes, which accrediting body has accredited this agency?

If not, and national accreditation is required for the service(s) requested, provide your agency's strategic plan to achieve accreditation within the required timeframe for each service:

Service Description	Service Code	NPI	Taxonomy	Medicaid/IPRS (State-Funding)

☐ **Services to be REMOVED**

Service Description	Service Code	NPI	Taxonomy	Medicaid/IPRS (State-Funding)

Section C – Update Service Site Panel Limits

When submitting requests for panel limit changes, include all NPI/Loc, all populations and counties served. By submitting a request to update panel limits, **ALL PREVIOUS REQUESTS WILL BE REPLACED.** Please submit a list of ALL panel limits with each request.

Please submit a copy of the NCQA certification for any populations you have been certified to serve after your initial NCQA TCM certification.

Requested Effective Date:

Clinically Integrated Network (CIN):

Service Site Address	Eligibility	NPI	Location Code	Servicing County	MH/SUD Adult Full Panel Size	MH/SUD Child Full Panel Size	I/DD Full Panel Size	TBI Full Panel Size	TCL Full Panel Size	Innovatio ns Waiver Full Panel Size	TBI Waiver Full Panel Size	Co-occurring I/DD & BH Adult Full Panel Size	Co-occurring I/DD & BH Child Full Panel Size
	☐ Medicaid Direct ☐ Tailored Plan ☐ Both												
	☐ Medicaid Direct ☐ Tailored Plan ☐ Both												
	☐ Medicaid Direct ☐ Tailored Plan ☐ Both												
	☐ Medicaid Direct ☐ Tailored Plan ☐ Both												
	☐ Medicaid Direct ☐ Tailored Plan ☐ Both												

Service Site Address	Eligibility	NPI	Location Code	Servicing County	MH/SUD Adult Full Panel Size	MH/SUD Child Full Panel Size	I/DD Full Panel Size	TBI Full Panel Size	TCL Full Panel Size	Innovatio ns Waiver Full Panel Size	TBI Waiver Full Panel Size	Co-occurring I/DD & BH Adult Full Panel Size	Co-occurring I/DD & BH Child Full Panel Size
	☐ Medicaid Direct ☐ Tailored Plan ☐ Both												
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	☐ Medicaid Direct ☐ Tailored Plan ☐ Both												
	☐ Medicaid Direct ☐ Tailored Plan ☐ Both												
	☐ Medicaid Direct ☐ Tailored Plan ☐ Both												
	☐ Medicaid Direct ☐ Tailored Plan ☐ Both												
	☐ Medicaid Direct ☐ Tailored Plan ☐ Both												

Section D – Add/Update Professional License/Certification/Practitioner Name Change

Section D is used to add an already enrolled practitioner to your agency and to initiate enrollment for licensed practitioners and associate (provisionally licensed) practitioners not yet enrolled.

☐ Change a Professional License or Certification		Requested Effective Date:	
☐ TRANSITION from associate to full license ☐ Add a NEW license or certification ☐ Associate Licensed Practitioner			
Clinician Name:		NPI:	Taxonomy Number:
License Type:		Effective Date:	
License Number:		Lapse Date:	
Certification Type:		Effective Date:	
Certification Number:		Lapse Date:	

☐ Change a Practitioner Name		Requested Effective Date:	
Type of Practitioner: ☐ Licensed Practitioner with an Agency ☐ Licensed Independent Practitioner			
Former Name:		New Name:	
Effective Date:	Reason for Name Change:		

Section E – Add/Remove or Initiate Enrollment of a Practitioner

Section D is used to add an already enrolled practitioner to your agency and to initiate enrollment for licensed practitioners and associate (provisionally licensed) practitioners not yet enrolled. If the agency will be billing codes for this practitioner that are not currently in the agency contract, complete section B of this request to add the codes to the agency contract.

Type of Change:

Requested Effective Date:

☐ **ADD** a currently enrolled practitioner to your agency or to a different site within your agency ☐ **REMOVE** a practitioner from your agency/site ☐ **INITIATE** practitioner enrollment

Practitioner Information

Practitioner Name:

First

M.I.

Last

Date of Birth:

Social Security Number:

☐ Male☐ Female

Personal Email:

Personal Phone:

Mailing Address:

Street

City

State

Zip + 4

County

☐ Associate Licensed Practitioner

License Type:

License Number:

Practitioner NPI:

Practitioner Taxonomy:

Does this clinician currently provide services at any other provider agency? ☐ Yes ☐ No

If yes, list agency name:

Agency Contact Information

Contact Name:

Contact Phone:

Contact Email:

Include ALL enrolled service sites clinician is to be added or removed within your agency (do NOT use P.O. Box):

☐ Add ☐ Remove Service Site Address:			
	Street		City
	State	Zip + 4	County
☐ Add ☐ Remove Service Site Address:			
	Street		City
	State	Zip + 4	County
☐ Add ☐ Remove Service Site Address:			
	Street		City
	State	Zip + 4	County
☐ Add ☐ Remove Service Site Address:			
	Street		City
	State	Zip + 4	County
☐ Add ☐ Remove Service Site Address:			
	Street		City
	State	Zip + 4	County
☐ Add ☐ Remove Service Site Address:			
	Street		City
	State	Zip + 4	County
☐ Add ☐ Remove Service Site Address:			
	Street		City
	State	Zip + 4	County

Section F – Change Primary Contact/Address Information				
☐ Change Primary Contact			Requested Effective Date:	
Primary Contact to Remove:			Name of Contact to Add:	
Title:			Email:	
Phone:		Fax:		Contact for <i>(select all that apply)</i> : ☐ Appointments ☐ Authorizations ☐ Authorized to sign the Contract ☐ Billing ☐ Clinical ☐ Complaints/Grievances ☐ Enrollment ☐ General Administration ☐ HIPAA ☐ Human Resources ☐ Incident Reporting ☐ NC TOPPS Superuser ☐ Privacy/Security ☐ Other:
This change is confirmed for the following sites/addresses:				
Street		City		
State	Zip + 4	County		
Street		City		
State	Zip + 4	County		
Street		City		
State	Zip + 4	County		

☐ Change Mailing Address			Requested Effective Date:	
Service Site Name:				
New Mailing Address:				
	Street		City	
	State	Zip + 4	County	

Section G – Change NPI/Taxonomy Information

Changes must be made and will be verified in NCTracks prior to Alpha+ entry.

☐ **Change NPI Information**

Requested Effective Date:

☐ **ADD NPI**☐ **REMOVE NPI**Has this change been made in NCTracks? ☐ Yes ☐ No

NPI:

This NPI is for:

Name of Agency/Group/Individual:

☐ Agency☐ Group☐ Individual☐ Location☐ Service

Street

City

State

Zip + 4

County

☐ **Change Taxonomy Information**

Requested Effective Date:

☐ **ADD Taxonomy**☐ **REMOVE Taxonomy**Has this change been made in NCTracks? ☐ Yes ☐ No

Taxonomy:

NPI:

This Taxonomy is for:

Name of Agency/Group/Individual:

☐ Agency☐ Group☐ Individual☐ Location☐ Service

Street

City

State

Zip + 4

County

Section H – LIP to Agency/Agency to LIP Contract Change

Requested Effective Date:

☐ Current LIP contract with Partners, requesting Agency contract☐ Current Agency contract with Partners, requesting LIP contract

Current Organization/LIP Name:

New Organization/LIP Name (if applicable):

Section I – Other Changes

Use Section H to describe changes not addressed in other sections.

Requested Effective Date:

Please describe other changes you wish to make that have not been addressed on this form: