

Temporary Disruption to Service Delivery Form

Submit fully completed form to:

Physical Health Providers: PHPAS@PartnersBHM.org

Behavioral Health Providers: PAS@PartnersBHM.org

Provider Name:	Date form submitted:	Name of person submitting form:
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Phone Number:	Email:
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Any additional provider staff that needs to be contacted (include phone number and email)

Name:	Phone:	Email:
Name:	Phone:	Email:
Name:	Phone:	Email:
Name:	Phone:	Email:
Name:	Phone:	Email:

Contracted Address of site to be temporarily relocated:	City:	State:	Zip Code:	County:
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Temporary Changes to Service Delivery

Service Location Address:	City:	State:	Zip Code:	County:
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Service Location NPI:	Phone:	Email:
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Please list any disruption to member care:

How many members' care has been disrupted?

Action Plan

Provide any actions and alternative efforts to minimize the impact of service disruption:

How long do you anticipate the disruption to member care and the use of alternative means to meet member need?

Do you have the capacity to accept new members? If so, how many and under what service lines?

For enhanced service providers, please specify if there will be any disruption or impact on your ability to meet First Responder requirements:

If so, what is your plan for informing Partners, member and/or guardian?