Vaya Health

Provider Change Request Form

Complete this form to request a change to your information with Vaya Health (Vaya).

Date of request: ___________________________

PROVIDER INFORMATION

1. **Identify provider type:**
   - ☐ Agency contracted with Vaya Health
   - ☐ Licensed independent practitioner (LIP) contracted with Vaya
   - ☐ Licensed practitioner (LP) w/ agency
2. **Legal name of provider:**

   ____
3. **Federal tax ID No. or Social Security No.:** __________________ **Provider's NPI No.:** __________________
4. **Mailing address:**

   _________________________________ _________________________ ____ _____________ __________________
   Street address or P.O. Box *City* *State* *ZIP+4* *County*

CONTACT INFORMATION

1. **Primary contact name:** ____
2. **Primary contact title:** ____
3. **Email address:** ____
4. **Telephone:** _________________________ _________________________ _________________________
   Office *Mobile* *Fax*

SUBMIT THIS COMPLETED, SIGNED REQUEST FORM TO:

Vaya Health
Credentialing Team
200 Ridgefield Court, Suite 206
Asheville, NC 28806

OR

CredentialingTeam@vayahealth.com

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DOCUMENT CHECKLIST

	CHECK THE CHANGE(S) REQUESTED BELOW:		SECTION TO COMPLETE:	ADDITIONAL DOCUMENTS REQUIRED?
	Remove site(s)/address	*(Agency or LIP only)*	Section A	Yes
	Remove service(s)	*(Agency or LIP only)*	Section B	Yes
	Update professional license/certification	*(LIP or LP only)*	Section C	Yes
	Change practitioner name	*(LIP or LP only)*	Section C	Yes
	Add/remove a credentialed practitioner	*(Agency or LIP only)*	Section D	Yes, if adding
	Change contact information	*(Agency, LIP or LP)*	Section E	No
	Change NPI number	*(Agency, LIP or LP)*	Section F	Yes
	Change taxonomy code	*(Agency, LIP or LP)*	Section F	Yes
	Update facility license/certification and/or accreditation	*(Agency, LIP or LP)*	Section G	Yes
	Change agency name	*(Agency only)*	Section G	Yes
	Add/change assumed name (ex. d/b/a)	*(Agency or LIP only)*	Section G	Yes
	Add/change ownership %, owners and/or managing employees	*(Agency or LIP only)*	Section G	Yes
	Change entity type	*(Agency or LIP only)*	Section H	Yes
	Other changes	*(Agency, LIP or LP)*	Section I	Yes

SIGNATURE AND ATTESTATION

By signing below, I hereby acknowledge, agree and 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, suspension or termination of any and all agreements with Vaya Health (Vaya). **Submission of this request does not guarantee approval of the same.**

I further acknowledge, agree and signify my willingness for Vaya to verify any and all information presented in this request. I agree to submit any additional information upon request to verify the accuracy and truthfulness of the information contained herein or submitted herewith and to address any issues that may arise during the processing of this request. I hereby give my consent for Vaya to interview or gather additional information from any individuals that may have information related to the requests herein. Finally, I attest that I am not aware of any conflict of interest existing between Vaya and the requesting provider or me.

If I am changing the name, federal or state tax identification number, and/or entity type of a Vaya-contracted licensed independent practitioner or agency, by signing below I expressly acknowledge, agree and certify that the licensed independent practitioner or agency (as applicable) that exists after the change to name, tax identification, and/or entity type in whatever form, agrees without objection the terms and conditions of any and all agreements, including, but not limited to, and only by way of example, contracts, purchase orders, memoranda of understanding, memoranda of agreement and/or maintenance of effort agreements, entered into and in existence by, between and among Vaya and provider immediately prior to the approval of the request(s) herein.

____
Provider name (print)

____
Date

____
Signature of Legally Authorized Representative

____
Title of Legally Authorized Representative (print)

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SECTION A: REMOVE SITE(S)/ADDRESS

Completed by Agency or LIP only

Requested effective date: ___________________________

Address type: ☐ Physical service site address ☐ Administrative notice address ☐ Billing address
☐ Mailing address for Agency's or LIP's credentialing correspondence
☐ Mailing address for LP's credentialing correspondence

Request for: ☐ Agency ☐ LIP ☐ LP

Address to be removed:

____________________	____________________	____	__________	__________
Street address or P.O. Box	*City*	*State*	*ZIP+4*	*County*

Site/facility name: ____ **Site NPI No.:** ____________________

Why are you requesting this removal of site?

____

Are there licensed practitioners at this location? ☐ Yes ☐ No *(If yes, attach a list of practitioners and NPI numbers.)*

Have services been delivered to Vaya members from this site within the last 90 days? ☐ Yes ☐ No

(If yes, please note that this change may require arrangements for discharge/closure and/or proper notice to members and Vaya, as detailed in your contract. Attach a narrative that fully explains the following:

- *Rationale for the removal of this site*
- *Number of members currently receiving services through this site*
- *Impact on members and the plan for discharge/continuation of services*
- *Impact on staff/number of staff affected*
- *Records management plan*
- *Plan for attending to other obligations detailed in your network contract with Vaya*

Note: For questions regarding discharge planning/notice requirements, please contact your agency's assigned Provider Relations Specialist. If you do not have an assigned Provider Relations Specialist, contact Vaya Provider Info at Provider.Info@vayahealth.com.)

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SECTION B: REMOVE SERVICE(S)

Completed by Agency or LIP only

Requested effective date: ______________________________

Physical site address:

______________________________________ ______________________________ ____ __________________ ____________________
Street address or P.O. Box *City* *State* *ZIP+4* *County*

Site/facility name: ____ **Site NPI No.:** _______________________

Provide the following information for all services to be *removed*:

SERVICE DESCRIPTION	SERVICE CODE	NPI #	TAXONOMY #	MEDICAID/NON-MEDICAID FUNDING

Why are you requesting this removal of service?

____

Are there licensed practitioners at this location? ☐ Yes ☐ No *(If yes, attach a list of practitioners and NPI numbers.)*

Have services been delivered to Vaya members from this site within the last 90 days? ☐ Yes ☐ No

(If yes, please note that this change may require arrangements for discharge/closure and/or proper notice to members and Vaya, as detailed in your contract. Attach a narrative that fully explains the following:

- *Rationale for the removal of this site*
- *Number of members currently receiving services through this site*
- *Impact on members and the plan for discharge/continuation of services*
- *Impact on staff/number of staff affected*
- *Records management plan*
- *Plan for attending to other obligations detailed in your network contract with Vaya*

Note: For questions regarding discharge planning/notice requirements, please contact your agency's assigned Provider Relations Specialist. If you do not have an assigned Provider Relations Specialist, contact Vaya Provider Info at Provider.Info@vayahealth.com.)

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SECTION C: ADD/UPDATE PROFESSIONAL LICENSE OR CERTIFICATION, CHANGE PRACTITIONER NAME

Completed by LIP or LP only

Complete Section C to update information on licensed practitioners currently credentialed with Vaya and employed or under contract with a Vaya-contracted agency or individual practice. Section D is used for a licensed practitioner currently credentialed with Vaya to affiliate with an agency or individual practice. To initiate credentialing for licensed practitioners and associate (provisionally licensed) practitioners not yet credentialed by Vaya, refer to the credentialing instructions at http://vayahealth.com/providers/credentialing/.

Note: You are responsible for adding/updating these changes in CAQH. This request will not be approved prior to CAQH being updated with the necessary information.

Requested effective date: ____________________________

Type of change: ☐ Change a license or certification ☐ Change practitioner name

Practitioner NPI No.: ______________________________ **Taxonomy code:** ____________________________

CAQH number: ______________________________

Email: ____ **Phone number:** ____________________________

ADD/UPDATE PROFESSIONAL LICENSE OR CERTIFICATION:

(Attach a copy of license/certification from your board.)

☐ **TRANSITION from associate to full license** ☐ **License or certification RENEWAL**
☐ **Add a NEW license or certification** ☐ **Lapse in license or certification**

Clinician name: ____

License type: ____________________ **Number:** ___________ **Effect. date:** ____________ **Lapse date:** ____________

Certification type: ____________________ **Number:** ___________ **Effect. date:** ____________ **Lapse date:** ____________

Reason for lapse or hold, if applicable: ____

CHANGE PRACTITIONER NAME:

Type of practitioner: ☐ Licensed practitioner with an agency
☐ Licensed independent practitioner *(Attach copy of new W-9 form.)*

FORMER name: ____ **NEW name:** ____

Date of name change: _______________ **Reason for name change:** ____

Attach supporting documentation indicating name change (e.g., driver's license, state-issued ID card, marriage certificate, U.S. passport, Social Security card, change of name documents, new W-9).

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SECTION D: ADD/REMOVE A CREDENTIALED PRACTITIONER

Completed by Agency or LIP only

Complete Section D to add or remove a licensed practitioner currently credentialed with Vaya. To initiate credentialing for licensed practitioners and associate (provisionally licensed) practitioners not yet credentialed by Vaya, refer to the credentialing instructions at http://vayahealth.com/providers/credentialing/.

Requested effective date: ______________________ **Request made by:** ☐ Agency ☐ LIP

Type of change: *(Check all that apply):*

- ☐ **ADD** a credentialed practitioner to your agency or individual practice.
- ☐ **REMOVE** a credentialed practitioner from your agency or individual practice.
- ☐ **REMOVE** a credentialed practitioner from a previous employer. (**Practitioner must sign below)**
- ☐ **REMOVE** a credentialed practitioner from the Vaya network. (**Practitioner must sign below)**

***(NOTE TO PRACTITIONER: REMOVAL** from the Vaya network will automatically **terminate** the licensed practitioner with Vaya. Should you wish to re-establish credentials with Vaya in the future, you will need to re-apply as a new practitioner in the Vaya closed provider network.)*

Reason for request:

ADD/REMOVE PRACTITIONER

Provide the following when adding a practitioner to your agency or individual practice:

Professional liability: *Provide a Certificate of Insurance/Memorandum of Insurance (COI/MOI) reflecting Professional Liability Insurance coverage protecting the practitioner for an amount of not less than $1,000,000.00 per occurrence/$3,000,000.00 annual aggregate. The Certificate of Insurance is required to* ***ADD*** *a credentialed practitioner with your agency/individual practice. The COI/MOI needs to include the name of the practitioner you are adding or a cover letter signed by a legally authorized representative of the provider stating that the practitioner is covered by the policy. The cover letter should include the policy number and effective dates.*

Agency name: ______________________ **Practitioner name:** ______________________

Practitioner NPI No.: ______________________ **Taxonomy code:** ______________________

Date of birth: ______________________ **CAQH number:** ______________________

Email address: ______________________ **Telephone:** ______________________

License type: ______________________ **License number:** ______________________

Issue date: ______________________ **Expiration date:** ______________________

Service site address: ______________________

Street address or P.O. Box *City* *State* *ZIP+4* *County*

REMOVE PRACTITIONER FROM PREVIOUS EMPLOYER/VAYA CLOSED PROVIDER NETWORK:

Name of provider you are leaving: ______________________ **Last date of employment:** ______________________

Prior provider's contract person: ______________________ **Contact number:** ______________________

______________________ ______________________ ______________________

Practitioner's printed name *Signature* *Date*

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SECTION E: CHANGE CONTACT INFORMATION

Completed by Agency, LIP or LP

Requested effective date: ______________________________

Remove this contact: ______________________________

Add this contact: ______________________________

Contact title: ______________________________

Email address: ______________________________

Telephone: ______________________________

Fax number: ______________________________

CONTACT THE NEW PERSON FOR:
(Select all that apply)

- ☐ Main contact
- ☐ Claims/billing
- ☐ Authorizations
- ☐ Office manager
- ☐ HR/personnel
- ☐ Intakes
- ☐ Referrals
- ☐ Complaints
- ☐ Incident reports
- ☐ Compliance Officer
- ☐ HIPPA privacy
- ☐ HIPAA Security Officer
- ☐ Records custodian
- ☐ Insurance
- ☐ Agency credentialing
- ☐ Practitioner credentialing
- ☐ Other: ______________________________

Reason for change:

____

This change is requested for the following sites/locations:

Street address or P.O. Box	City	State	ZIP+4	County

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SECTION F: CHANGE NPI NO., TAXONOMY INFORMATION

Completed by Agency, LIP or LP

CHANGE NPI NUMBER: *(Attach a copy of the taxonomy code and NCTracks documentation.)*

Requested effective date: ____________________________

Type of change: ☐ Add NPI ☐ Revise NPI (NPI correction) ☐ Remove NPI

This NPI is for: ☐ Agency ☐ LIP ☐ LP

NPI number: _______________________ **Name of individual or agency:** ____

AlphaMCS site ID: _______________________

Site address:

__________________________________ ___________________________ _____ _______________ __________________

Street address or P.O. Box *City* *State* *ZIP+4* *County*

Reason for change:

____

Note: A change to a NPI number will not take effect until and unless the change to the NPI is applied and reflected in NCTracks.

CHANGE TAXONOMY CODE: *(Attach a copy of the Taxonomy Code and NCTracks documentation.)*

Requested effective date: ____________________________

Type of change: ☐ Add taxonomy ☐ Revise taxonomy (taxonomy correction) ☐ Remove taxonomy

This NPI is for: ☐ Agency ☐ LIP ☐ LP

Taxonomy code: ______________________ **Name of individual or agency:** ____

This taxonomy is associated w/ NPI no.: _______________________________

AlphaMCS site ID: ______________________

Site address:

__________________________________ ___________________________ _____ _______________ __________________

Street address or P.O. Box *City* *State* *ZIP+4* *County*

Reason for change:

____

Note: A change to a Taxonomy Code will not take effect until and unless the change to the NPI is applied and reflected in NCTracks.

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SECTION G: UPDATE FACILITY LICENSE/CERTIFICATION, ACCREDITATION, OWNERSHIP INFORMATION, AGENCY NAME AND/OR ASSUMED NAME (d/b/a)

Completed by Agency or LP only

Requested effective date: ______________________________

Federal tax ID No. or SSN: ______________________________

NPI number: ______________________________

Type of change:
- ☐ Update facility license/certification
- ☐ Add/change agency accreditation
- ☐ Change of agency name and/or assumed name
- ☐ Change in ownership %/managing employees

UPDATE FACILITY LICENSE/CERTIFICATION: *(Attach a copy of the facility license/certification.)*

Type of update: ☐ License update ☐ License renewal

______________________	______________________	____	____________	____________
Street address or P.O. Box	*City*	*State*	*ZIP+4*	*County*

Type of facility license/certification: ____________________________ **Issue date**: _____________ **Expiration date:** _____________

ADD/CHANGE AGENCY ACCREDITATION: *(Attach a copy of the accreditation.)*

☐ Add accreditation ☐ Change accreditation

Accreditation body: ____ **Issue date**: _____________ **Expiration date:** _____________

CHANGE AGENCY NAME *(Agency only)* AND/OR ASSUMED NAME:

(Attach a copy of completed IRS Form W-9 and name change documents filed with N.C. Secretary of State or assumed name document recorded with the applicable county Register of Deeds.)

Type of change: ☐ Change Agency's legal name ☐ Add/change assumed name (ex. d/b/a)

Previous agency name/assumed name (d/b/a): ____

New agency name/assumed name (d/b/a): ____

ADD/CHANGE OWNERSHIP AND/OR MANAGING EMPLOYEES:

(Attach a copy of each person's authorization and release.)

Type of change: ☐ Add/change ownership ☐ Add/change managing employees

Current owner(s) with 5% or more ownership interest: ____

New owner(s) with 5% or more ownership interest: ____

For mergers, indicate the Merging Entity: ____

Surviving Entity: ____

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Name and home address		Title	SSN	License #	% Owner	Date of birth
Name:						
Street address:		Check business relationship that applies: ☐ Owner ☐ Managing employee ☐ Shareholder ☐ EFT-authorized individual ☐ Partner				
City:						
State:	ZIP code:					

Name and home address		Title	SSN	License #	% Owner	Date of birth
Name:						
Street address:		Check business relationship that applies: ☐ Owner ☐ Managing employee ☐ Shareholder ☐ EFT-authorized individual ☐ Partner				
City:						
State:	ZIP code:					

Name and home address		Title	SSN	License #	% Owner	Date of birth
Name:						
Street address:		Check business relationship that applies: ☐ Owner ☐ Managing employee ☐ Shareholder ☐ EFT-authorized individual ☐ Partner				
City:						
State:	ZIP code:					

Name and home address		Title	SSN	License #	% Owner	Date of birth
Name:						
Street address:		Check business relationship that applies: ☐ Owner ☐ Managing employee ☐ Shareholder ☐ EFT-authorized individual ☐ Partner				
City:						
State:	ZIP code:					

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SECTION H: CHANGE ENTITY TYPE

Completed by Agency or LP only

CURRENT entity type:

- ☐ C-Corporation
- ☐ S-Corporation
- ☐ Limited liability corporation
- ☐ General partnership
- ☐ Sole proprietorship
- ☐ Limited liability partnership
- ☐ Cooperative
- ☐ Not-for-profit
- ☐ Government

NEW entity type:

- ☐ C-Corporation
- ☐ S-Corporation
- ☐ Limited liability corporation
- ☐ General partnership
- ☐ Sole proprietorship
- ☐ Limited liability partnership
- ☐ Cooperative
- ☐ Not-for-profit
- ☐ Government

COMPLETE THE FOLLOWING FOR ALL TYPES OF OWNERSHIP CHANGES:

1. **Has the organization ever been sanctioned, placed on probation or lost accreditation or certification status?**

   ☐ Yes (If yes, *attach an explanation of the circumstances and how it was resolved.)*

   ☐ No

2. **Has there ever been any action or investigation against you or any owner or qualified professional in your organization relating to any if the following?** *(If yes, attach an explanation.)*

   a. License ☐ Yes ☐ No

   b. Certification ☐ Yes ☐ No

   c. Registration ☐ Yes ☐ No

   d. Privileges ☐ Yes ☐ No

   e. Billing organizations ☐ Yes ☐ No

   f. Sanctions ☐ Yes ☐ No

3. **Have any adverse actions been filed against you by any of the following?** *(If yes, attach an explanation.)*

   a. Medicaid? ☐ Yes ☐ No

   b. Medicare? ☐ Yes ☐ No

   c. Other insurance? ☐ Yes ☐ No

4. **Has anyone in your company who has an ownership, managerial or clinical role ever been sanctioned by any professional organization or government organization for violation of ethics, professional misconduct, unprofessional conduct, incompetence or negligence in any state or country?** *(If yes, attach an explanation.)*

   ☐ Yes ☐ No

5. **Are you aware of any circumstance that may result in such action?** *(If yes, attach an explanation.)*

   ☐ Yes ☐ No

6. **Have you ever had a contract cancelled by another LME/MCO, area authority or county program in North Carolina or similar entity in another state?** *(If yes, attach an explanation.)*

   ☐ Yes ☐ No

7. **Attach a page identifying all owner(s), managing employee(s) and Electronic Funds Transfer (EFT)-authorized individuals and information requested on each.** All individuals listed in this section must complete and submit a Release and Consent for Background Check, available at http://vayahealth.com/providers/credentialing/.

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SECTION I: OTHER CHANGES

Completed by Agency, LIP or LP

Requested effective date: ____________________________

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

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