|  |  |
| --- | --- |
|  | **Provider Change/Add/Delete Request Form**Please complete this form if you are requesting to submit a change to Partners Behavioral Health Management, and/or Smoky Mountain LME/MCO provider networks.  |

**Date of Request:**

# PROVIDER INFORMATION

Please identify your provider type:

[ ]  Agency [ ]  Agency/ Licensed Facility

[ ]  Group Practice [ ]  Facility only (for example, PRTF only)

[ ]  CABHA [ ]  Licensed Independent Practitioner (LIP)

[ ]  Licensed Practitioner (LP)

**MCOs that will be affected by this change:**

Check all that apply[ ]  Partners Behavioral Health Management

 [ ]  Smoky Mountain LME/MCO

# PROVIDER INFORMATION

1. Legal Name of Organization:
2. Federal Tax ID/Social Security Number:
3. Primary Address:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|        |        |   |            |        |
| Street/PO Box  | City | State | Zip + 4  | County |

1. Phone Number:
2. Licensed Practitioner Name (if applicable):
3. Licensed Practitioner NPI# (if applicable):

# CONTACT INFORMATION

1. Primary Contact Name:
2. Primary Contact Title:
3. Primary Contact Email Address:

|  |  |  |  |
| --- | --- | --- | --- |
| 1. Telephone:
 | Office:            | Mobile:            | Fax:            |

**Please submit this completed, signed Provider Change/Add/Delete Request Form to:**

Smoky Mountain LME/MCO

Credentialing Team | 200 Ridgefield Ct. Suite 206 | Asheville, NC 28806 or

credentialingteam@smokymountaincenter.com

# DOCUMENT CHECKLIST

|  |  |  |
| --- | --- | --- |
| **Check the change(s) requested below** | **Complete** | **Supporting Documents Required?** |
| [ ]  Remove Site(s)/Address | Section A | Yes |
| [ ]  Remove Service(s) | Section B | Yes |
| [ ]  Add/Update Professional License/Certification, Practitioner Name Change  | Section C | Yes |
| [ ]  Add/Remove a Credentialed Practitioner | Section D |  |
| [ ]  Change Primary Contact Information  | Section E |  |
| [ ]  Change NPI Number | Section F |  |
| [ ]  Change Taxonomy Code | Section F |  |
| [ ]  Update Business License, Ownership Info orEntity Type | Section G |  |
| [ ]  Other Changes | Section H | Yes |

**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 furtherunderstand that any false or misleading information may be cause for denial or termination of any and all agreements with the applicable LME/MCO. **Submission of this request does not guarantee approval.**

I further signify my willingness for the LME/MCO 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 LME/MCO to interview any individuals that may have information related to this request or the qualification(s) related to the applicant/organization.

Finally, I attest that I am not aware of any conflict of interest existing between the applicable LME/MCO(s) and the Applicant.

 Print Name Print Title

Signature of Legally Authorized Representative Date

**Section A | Remove a Site/Address**

**Requested Effective Date:**

**Address Type:** [ ]  Mailing Address [ ]  Billing Address

 [ ]  Service Site Address [ ]  Administrative Address

Address to be **removed**:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|       |       |   |            |        |
| Street/PO Box  | City | State | Zip + 4  | County |

Phone #:            Fax #:

Site/Facility Name:

Site NPI:

Please complete the following for all services provided at this location:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Service Description** | **Service Code** | **NPI #** | **Taxonomy#** | **Medicaid/****IPRS (state) Funding** |
|       |       |       |       |       |
|       |       |       |       |       |
|       |       |       |       |       |
|       |       |       |       |       |
|       |       |       |       |       |
|       |       |       |       |       |

*Please attach additional pages as needed.*

**Are Licensed Practitioners at this location?** [ ]  Yes [ ]  No

*If yes, please attach a list of practitioners and NPI #s*

**Instructions to Remove a Site**

This change requires arrangements for discharge/closure, and adequate notice to consumers and the MCO as detailed in your contract. Please attach a narrative that fully explains the following:

* Rationale for the removal of this site
* Number of consumers currently in treatment
* Impact on consumers 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 the MCO.

**Section B | Remove a Service**

**Requested Effective Date:**

**Provide the following:**

Site/Facility Name:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|       |       |   |            |       |
| Street | City | State | Zip + 4  | County |

Site NPI:

Phone #:            Fax #:

Please provide the following for all services to be **removed**:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Service Description** | **Service Code** | **NPI #** | **Taxonomy#** | **Medicaid/****IPRS (state) Funding** |
|       |       |       |       |       |
|       |       |       |       |       |
|       |       |       |       |       |
|       |       |       |       |       |
|       |       |       |       |       |
|       |       |       |       |       |

**Are Licensed Practitioners at this location?** [ ]  Yes [ ]  No

*If yes, please attach a list of practitioners and NPI #s*

**Instructions to Remove a Service(s)**

This change requires arrangements for discharge/closure, and adequate notice to consumers and the MCO as detailed in your contract. Please attach a narrative that fully explains the following:

* Rationale for the removal of this service
* Number of consumers currently in treatment
* Impact on consumers 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 the MCO.

**Section C | Add/Update Professional License/Certification, Practitioner Name Change**

*Complete Section C to update information on licensed practitioners already credentialed with the MCO and connected with your agency. Section D is used to add an already credentialed practitioner to your agency. To initiate credentialing for licensed practitioners and associate (provisionally licensed) practitioners not yet credentialed by the MCO, refer to Smoky credentialing instructions at* [*http://www.smokymountaincenter.com/credentialing/*](http://www.smokymountaincenter.com/credentialing/)*.*

**Note:** Updates provided in this section also need to be updated in CAQH

**Requested Effective Date:**

**Type of Change** [ ]  Change a License or Certification [ ]  Change Practitioner Name

**Provide the following for all changes:**

Practitioner NPI#:       CAQH #:

Email:       Phone #:

**Change a Professional License or Certification**

*Please attach a copy of license/certification from your board*

[ ]  **TRANSITION** from associate to full license

[ ]  Add a **NEW** License or Certification

[ ]  License **RENEWAL**

Clinician Name:

License Type:       Number:       Effect. Date:       Lapse Date:

Certification Type:       Number:       Effect. Date:       Lapse Date:

**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:

Effective Date:       Reason for Name Change:

*Attach supporting documentation indicating name change (e.g., Drivers License, State issued ID card, Marriage certificate, U.S. Passport, Social Security card, change of name documents, new W-9)*

**Section D | Add/Remove a Credentialed Practitioner**

*Complete Section D to add or remove an* already *credentialed practitioner for a contracted agency. To initiate credentialing for licensed practitioners and associate (provisionally licensed) practitioners not yet credentialed by the MCO, refer to Smoky credentialing instructions at* [*http://www.smokymountaincenter.com/credentialing/*](http://www.smokymountaincenter.com/credentialing/)*.*

**Requested Effective Date:**

**Type Practitioner:** [ ]  Licensed Practitioner (LP)

[ ]  Associate Practitioner (provisionally licensed)

**Type Change:** [ ]  **ADD** a credentialed Practitioner

Check all that apply [ ]  **REMOVE** practitioner from a previous employer. **This action must be by the practitioner.**

 [ ]  **REMOVE** a credentialed Practitioner from your agency

 [ ]  **REMOVE** a credentialed Practitioner from the MCO Network **NOTE:** This action will **terminate** your credentials with the MCO network. Should you wish to re-establish credentials with the MCO in the future, you will need to re-apply as a new practitioner. **This action must be signed by the practitioner.**

**Provide the following for all practitioner changes:**

*Attach evidence of insurance coverage to ADD a credentialed Practitioner with your agency*

Agency Name:

Practitioner Name:

Practitioner NPI#:       Date of Birth:       CAQH #:

Email:       Phone #:

License Type:       License #:

Issue Date:       Expiration Date:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|       |       |   |            |        |
| StreetService site addressSite Contact Person:       | City | State | Zip + 4  | County |

**Remove Practitioner from Previous Employer**

Name of Agency you are leaving:       Last Date of Employment

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|       |       |   |            |        |
| StreetService site addressSite Contact Person:       | City | State | Zip + 4  | County |

Practitioners Printed Name Signature Date

**Section E | Change Primary Contact Information**

|  |  |
| --- | --- |
| **Change Primary Contact****Effective Date:**      **Delete this Contact:**      **Add this Contact:**      Title:      E-mail:      Phone #:       Fax#:       | Contact this person for: *(select all that apply)*[ ]  Billing[ ]  Contracts[ ]  Appointments[ ]  Clinical [ ]  General Administrative[ ]  Human Resources[ ]  Community Care of North Carolina (CCNC)[ ]  Other       |

This change is confirmed for the following sites/locations:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|       |       |   |            |       |
| Street/PO Box  | City | State | Zip + 4  | County |
|       |       |   |            |       |
| Street/PO Box  | City | State | Zip + 4  | County |
|       |       |   |            |       |
| Street/PO Box  | City | State | Zip + 4  | County |

**Section F | Change NPI / Taxonomy Information**

**Change NPI Information**

**Effective Date:**

**Type Change:** [ ]  Add NPI

[ ]  Revise NPI (NPI correction)

 [ ]  Remove NPI

**This NPI # is for:** [ ]  Individual [ ]  Agency [ ]  Group

 [ ]  Location [ ]  Service

NPI #:       Name of Individual/Group/Agency:

Service Site Name:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|       |       |   |            |        |
| Street/PO Box  | City | State | Zip + 4  | County |

Reason for Change:

Attach a copy of the NPPES and NC Tracks documentation

**Change Taxonomy Information**

**Effective Date:**

**Type Change:** [ ]  Add Taxonomy

[ ]  Revise Taxonomy (Taxonomy correction)

 [ ]  Remove Taxonomy

**This Taxonomy is for:** [ ]  Individual [ ]  Agency [ ]  Group

 [ ]  Location [ ]  Service

Taxonomy #:       Name of Individual/Group/Agency:

Service Site Name:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|       |       |   |            |        |
| Street/PO Box  | City | State | Zip + 4  | County |

Reason for Change:

Attach a copy of the Taxonomy Code and NC Tracks documentation

**Section G| Update Business License, Ownership Info or Entity Type**

*Use Section F for updates to business information.*

**Requested Effective Date:**       **Type of Change:**

[ ]  Update Business License

 [ ]  Change in Ownership

 [ ]  Change of Business Entity Type

**Update Business License**

*Attach a copy of the business license*

**Tax ID #:**       [ ]  License Update [ ]  License Renewal

Business Name:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|       |       |   |            |        |
| Street/PO Box  | City | State | Zip + 4  | County |

Type of Business License:

Issue Date:       Expiration Date:

**Change of Ownership**

Agency Name:

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

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

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|       |       |   |            |        |
| Street/PO Box  | City | State | Zip + 4  | County |

Tax ID #:       Type: [ ]  Social Security Number (SSN)

 [ ]  Employer Identification Number (EIN)

 [ ]  Other:

For mergers indicate - Merging Entity:

 Surviving Entity:

**Change of Business Entity Type**

Current Entity Type:

[ ]  C-Corporation [ ]  General Partnership  [ ]  Cooperative

[ ]  S-Corporation [ ]  Sole Proprietorship  [ ]  Not for Profit

[ ]  Limited Liability Corporation  [ ]  Limited Liability Partnership  [ ]  Government

New Entity Type:

[ ]  C-Corporation [ ]  General Partnership [ ]  Cooperative

[ ]  S-Corporation [ ]  Sole Proprietorship [ ]  Not for Profit

[ ]  Limited Liability Corporation [ ]  Limited Liability Partnership [ ]  Government

**Complete the following of all types of ownership change:**

1. **Has the Organization ever been sanctioned, placed on probation, or lost accreditation or certification status?**  Yes [ ]  No [ ]

*If yes, attach an explanation of the circumstances and how it was resolved*

1. **Has there ever been any action or investigation against you or any owner or qualified professional in your Organization relating to:**

*If yes, attach an explanation*

**Yes No**

* 1. License?**[ ]** **[ ]**
	2. Certification? **[ ]** **[ ]**
	3. Registration?**[ ]** **[ ]**
	4. Privileges?**[ ]** **[ ]**
	5. Billing Organizations?**[ ]** **[ ]**
	6. Sanctions?**[ ]** **[ ]**
1. **Have any adverse actions been filed against you by:**

*If yes, attach an explanation*

**Yes No**

* 1. Medicaid?**[ ]** **[ ]**
	2. Medicare?**[ ]** **[ ]**
	3. Other Insurance?**[ ]** **[ ]**
1. **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**

**[ ]** **[ ]**

1. **Are you aware of any circumstance that may result in such action?**

*If yes, attach an explanation*

 **Yes No**

 [ ]  [ ]

1. **Have you ever had a contract cancelled by another LME/MCO/Area Authority/County Program in North Carolina or similar entity in another state?**

*If yes, attach an explanation*

 **Yes No**

[ ]  [ ]

Identify 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 found at [www.smokymountaincenter.com/credentialing](http://www.smokymountaincenter.com/credentialing).

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Name and Home Address | Title | SSN | License # | % Owner | Date of Birth |
|      Name |       |       |       |       |       |
|      Home Street Address | Check business relationship that applies:[ ]  Owner[ ]  Shareholder [ ]  Partner[ ]  Managing Employee[ ]  EFT Authorized Individual  |
|      City |  |
|   State |      Zip Code |  |
| Name and Home Address | Title | SSN | License # | % Owner | Date of Birth |
|      Name |       |       |       |       |       |
|      Home Street Address | Check business relationship that applies:[ ]  Owner[ ]  Shareholder [ ]  Partner[ ]  Managing Employee[ ]  EFT Authorized Individual |
|      City |  |
|   State |      Zip Code |  |
| Name and Home Address | Title | SSN | License # | % Owner | Date of Birth |
|      Name |       |       |       |       |       |
|      Home Street Address | Check business relationship that applies:[ ]  Owner[ ]  Shareholder [ ]  Partner[ ]  Managing Employee[ ]  EFT Authorized Individual  |
|      City |  |
|   State |      Zip Code |  |
| Name and Home Address | Title | SSN | License # | % Owner | Date of Birth |
|      Name |       |       |       |       |       |
|      Home Street Address | Check business relationship that applies:[ ]  Owner[ ]  Shareholder [ ]  Partner[ ]  Managing Employee[ ]  EFT Authorized Individual  |
|      City |  |
|   State |      Zip Code |  |

**Section H | Other Changes**

*Use Section G to describe changes not addressed in other sections (e.g., hours of operations, after hours coverage).*

**Requested Effective Date:**

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