CalOptima User Guide

ADD, CHANGE, AND TERMINATION (ACT) FORM

REQUIREMENTS
CalOptima requires its health networks (HN), subdelegates, providers, and practitioners to promptly inform us of any changes to information regarding practitioner:

- **Demographics**
- **Credentialing**
- **Panel status** - including accepting new patients, accepting existing patients, accepting through a referral, accepting through a facility or hospital, and not accepting new patients
- **Other information requested in this file**

HEALTH NETWORKS
All HNs and subdelegates shall promptly, but no later than five (5) business days from a change in the practitioner’s panel status, inform CalOptima of such change. The HN, on a quarterly basis, verifies and updates the practitioners' information. The HN verification process includes a methodology to audit and confirm the information provided by its practitioners is true and correct. HN maintains records of such verifications and shall provide them during the second and fourth quarters of the year.

ACT FORM INSTRUCTIONS
Please read through instructions carefully, which specifies the exact data content and data format of each column on the roster.

1. Do not change column name, column order, data format and do not add in new columns
2. Any column left "Blank" or null shall be rejected by the health plan
3. Submit any practitioner (i.e. PCP, specialist, mid-level) participating within your CalOptima network
4. Submit any practice location (medical office, clinic, etc.) participating within you CalOptima network
5. Submit any hospital that provides health care services to CalOptima members within your network, regardless of CalOptima contractual relationship
6. Submit any ancillary facility and its affiliated practitioners that provides health care services to CalOptima members within your network, regardless of CalOptima contractual relationship
7. All provider types (taxonomy and specialty)
   a. Must be credentialed
   b. Only the taxonomy and specialty that are contracted at the location
   c. Please refer to the taxonomy codes submitted on the sFTP for taxonomy code table
8. Practice locations must pass Facility Site Review (FSR) - Physician and mid-level
9. ACT Form submissions that deviate from the criteria listed above will be REJECTED and returned
10. E-mail completed ACT form and required support documents to ProviderOnline@caloptima.org
### HOW TO SUBMIT CALOPTIMA ACT FORM

1) Complete all relevant **sections** of the CalOptima ACT Form
2) Attached a competed and signed W9
3) Include a copy of the front of your HN contract and signature page or CCN/COD Contract Summary
4) Complete a provider profile that includes the following information:
5) E-mail completed ACT form and required support documents to ProviderOnline@caloptima.org
6) For questions and more information, call the CalOptima Provider Relations department at **714-246-8600**

### Scope of Provider Type

1) **Physician** (individual)
   - Medical Doctor (M.D.)
   - Doctor of Osteopathic Medicine (D.O.)
   - Doctor of Podiatric Medicine (D.P.M.)

2) **Mid-level** (individual)
   - Certified Nurse Practitioners (CNP)
   - Certified Nurse Midwives (CNM)
   - Physician Assistants (PA)

3) **Hospital**: Any hospital within HN network, regardless of CalOptima’s contractual relationship. Samples of but are not limited to the following:
   - Ambulatory Surgery Center
   - Hospital with Acute Care
   - Psychiatry Hospital

4) **Ancillary**: Any facility that provides health care services to CalOptima members within HN network, regardless of CalOptima contractual relationship. Examples include but are not limited to the following:
   - Adult Day Health Care Center/Community Base Adult Service
   - Audiology
   - Durable Medical Equipment
   - End-Stage Renal Disease Provider/Dialysis Unit/Hemodialysis
   - Home Health
   - Home Infusion
   - Hospice
   - Clinical Laboratory
   - Long Term Services and Supports
   - Occupational Therapy
   - Physical Therapy
   - Portable X-Ray Supplier
   - Radiology Center
   - Rehabilitation Center
   - Skilled Nursing Facility
   - Transportation Services
   - Urgent Care
   - Transportation Services
   - Urgent Care
   - … and others

**Practitioner Practices at Ancillary** (individual) – examples include are but not limited to the following:

- Acupuncturist
- Audiologist
- Chiropractor
- Physical Therapist
- Radiation Therapist
- Occupational Therapist
- Speech Therapist
- … and others
**WHEN SHOULD I SUBMIT AN ACT REQUEST?**

**Additions:** Term referred to in the Addition, Change and Termination (ACT) process to add a provider, practitioner or facility to CalOptima’s system. Health networks and subdelegates shall submit ACT forms and required documentation as outlined in this policy when adding a provider, practitioner or facility pursuant to the terms of the agreement. To add an additional location to an existing provider, please check the additional location box on Page 2 of the ACT form.

**Changes:** Term referred to in the Addition, Change and Termination (ACT) process to make a demographic or other change to a provider, practitioner or facility in CalOptima’s system. Health networks and subdelegates shall submit ACT forms and required documentation as outlined in this policy when making demographic or other changes to the CalOptima system pursuant to the terms of the agreement.

**Terminations:** Term referred to in the Addition, Change and Termination (ACT) process when terminating a provider, practitioner or facility from CalOptima’s system. Health networks and subdelegates shall submit notification of terminations pursuant to the terms of the agreement.

**ADDITIONAL SUBMISSION REQUIREMENTS**

**Additions:** When making an addition request, the group name, National Provider Identifier (NPI) and Tax Identification Number (TIN) must all correspond. In the event your submission consists of non-corresponding identifiers it will not be honored.

**Terminations:** When requesting a termination of a provider’s tax identification number, you must submit the group NPI along with the TIN.

**Health Networks and Subdelegates**

- Health networks and providers must take the following steps when requesting to move a provider from one group NPI to another group NPI:
  1. Submit ACT Termination form to remove the provider from the CalOptima system
  2. Submit ACT Addition form and required documentation as outlined in EE1101 to add the provider to the CalOptima system with the new group NPI

  *Note: Each of the above steps must be done separately*

- If you are adding or changing the address of a primary care provider (PCP), you must include the date of request along with a Facility Site Review (FSR) completion form with your submission request.

  E-mail completed ACT form and required support documents to ProviderOnline@caloptima.org

**Disclaimer** – For directory data integrity purposes, CalOptima will limit the registration of office locations outside of Orange County, for providers with multiple sites, to the following cities: Whittier, La Mirada, Cerritos, Hawaiian Gardens, Long Beach, Lakewood, La Habra Heights, Hacienda Heights, Diamond Bar and Rowland Heights. Provider office locations outside of these cities will NOT be loaded in the CalOptima Provider Directory.
Add, Change, and Termination Form

This form must be completed to report any additions, changes, and/or terminations to a provider's network affiliates. A separate form must be completed for each contracted provider terminated or whose status is being changed.

Health Network Name:

Line of Business (Check all that apply)
- [ ] Medi-Cal
- [ ] OneCare
- [ ] PACE
- [ ] OneCare Connect

PROVIDER INFORMATION

PROVIDER STATE LICENSE #

PROVIDER TIN #

TYPE 1 NPI (National Provider ID #)

PROVIDER ID

MEDICARE #

MEDICAID EFFECTIVE DATE

PROVIDER NAME (Last)

First

(Middle Initial)

PRIMARY TAXONOMY

SECONDARY TAXONOMY

TERTIARY TAXONOMY

ORDERING, REFERRING, PRESCRIBING (ORP) [ ] YES [ ] NO

AREA OF FOCUS

PRIMARY SPECIALTY

SECONDARY SPECIALTY

GROUP NAME

GROUP TYPE 2 NPI (National Provider ID #)

GROUP ID

GROUP TIN

SERVICE ADDRESS FOR AFFILIATION (See Page 2 for address changes and additional locations)

CITY

STATE

ZIP

OFFICE MANAGER

PHONE NUMBER

FAX NUMBER

PUBLIC E-MAIL ADDRESS

ADMINISTRATION EMAIL ADDRESS

WEBSITE URL ADDRESS

SPECIAL SERVICES

□ CCS

□ CHDP

□ CFSP

HOSPITAL / FACILITY AFFILIATIONS AND ADMITTING PRIVILEGES

1.

2.

3.

[ ] NONE [ ] ACTIVE [ ] ASSOCIATE STAFF

[ ] HONORARY [ ] CONSULTANT

[ ] COURTESY [ ] LIMITED [ ] PROVISIONAL

[ ] SENIOR ATTENDING [ ] SURGICAL

[ ] SUSPENDED

[ ] EMAIL ATTESTATION ON FILE

ACTION REQUIRED (Check all that apply)

NEW ADD OR AFFILIATION

□ ANCILLARY/ALLIED HEALTH

[ ] Open Panel / [ ] Closed Panel

[ ] PCP

[ ] SPECIALIST

[ ] Open Panel / [ ] Closed Panel

[ ] PCP

[ ] SPECIALIST

CHANGE IN PANEL STATUS

PROVIDER TYPE

PROVIDER TYPE (if applicable, check both)

TAX I.D. CHANGE

Requirements: The health network must attach a copy of the provider notification indicating the change of tax ID AND a new W-9 form.

Effective Date of New Tax I.D. (required)

Previous Tax I.D.

New Tax I.D.
### ADD, CHANGE, AND TERMINATION (ACT) FORM

**Termination**

- **Effective Date (required):**
  - [ ] PCP
  - [ ] SPECIALIST
  - [ ] ANCILLARY

- **Date CalOptima received the termination notice:**
- **Exceptions:** Review found that the terminated provider is exempt from continuing access based on the exemption checked below:
  - [ ] Provider not available
  - [ ] Provider retired
  - [ ] Contract not continued
  - [ ] Other:

- **PCP Termination:** Assign member to new PCP: ______________

- **Number of Members Impacted (As of Date Received):**
  - [ ] Medi-Cal
  - [ ] OneCare
  - [ ] OneCare Connect

- **Date Member Notice was mailed:**
- **Number of days’ notice provider gave to MCP:**

**Address/Phone Change or Additional Address**

- **Effective Date (required):**
  - [ ] ADD
  - [ ] TERM

- **Site Telehealth Indicators:**
  - [ ] Telehealth Only
  - [ ] No Telehealth
  - [ ] Both Telehealth and In-person

- **Address:**
  - [ ] City
  - [ ] State
  - [ ] Zip

- **Phone Number:**
- **Fax Number:**
- **Office Hours:**
- **After Hours Phone Number:**

- **Office Manager:**
- **E-mail Address:**

**Languages Spoken by Staff**

1. ______________
2. ______________
3. ______________

**Languages Spoken by Provider**

1. ______________
2. ______________
3. ______________

**Comments:**

---

I certify that the above information is true, accurate and complete to the best of my knowledge and that I am authorized to execute this document on behalf of the applicant. I understand that incorrect or inaccurate information may affect the applicant's eligibility to receive CalOptima reimbursement and that the applicant must report changes in the above information to the CalOptima Provider Enrollment Unit. I hereby further declare that the applicant listed above and its agents (a) have not been convicted of a criminal offense related to health care in the past seven (7) years and (b) have never been suspended, excluded, or otherwise ineligible to participate in federal and/or state health care programs based on a mandatory exclusion under 42 U.S.C. § 1395ee-7(a).

I hereby further certify that the applicant listed above and its agents will comply with all applicable laws including, without limitation, Medicare and Medi-Cal laws and regulations, and CalOptima’s Compliance Program. I acknowledge and agree that CalOptima may recoup reimbursement paid to any ineligible provider.

**Provider Relations Representative**

(please print)

**Provider Name**

(please print)

**Signature**

**Date**
Add, Change, and Termination Form

This form must be completed to report any additions, changes, and/or terminations to a provider's network affiliates. A separate form must be completed for each contracted provider terminated or whose status is being changed.

Health Network Name:

Line of Business (Check all that apply)
- Medi-Cal
- OneCare
- PACE
- OneCare Connect

Provider Information

Provider State License #
Provider TIN #

Type of NPI (National Provider ID #)

Provider ID
Medicare #
Medi-Cal Effective Date

Provider Name (Last)
(First)
(Middle initial)

Primary Taxonomy
Secondary Taxonomy
Tertiary Taxonomy
Ordering, Referring, Prescribing (ORP)
Yes
No

Area of Focus
Primary Specialty
Secondary Specialty

Group Name
Provider Telehealth Indicators
- Telehealth Only
- No Telehealth
- Both Telehealth and In-person

Group Type
- 2 NPI (National Provider ID #)
Group ID
Group TIN

Service Address for Affiliation (See Page 2 for address changes and additional locations)
City
State
ZIP

Remit Address
City
State
ZIP

Office Manager
Phone Number
Fax Number
Public Email Address

Administration Email Address
Website URL Address
Special Services
- CCS
- CHOP
- CPSP

Hospital / Facility Affiliations and Admitting Privileges

1. None
- Active
- Associate Staff
- Honorary
- Consultant
- Courtesy
- Limited
- Provisional
- Senior Attending
- Surgical
- Suspended

2. None
- Active
- Associate Staff
- Honorary
- Consultant
- Courtesy
- Limited
- Provisional
- Senior Attending
- Surgical
- Suspended

3. None
- Active
- Associate Staff
- Honorary
- Consultant
- Courtesy
- Limited
- Provisional
- Senior Attending
- Surgical
- Suspended

Email Attestation on File

Action Required (Check all that apply)

- New Add or Affiliation
  - ANCILLARY/ALLIED HEALTH
  - PCP
  - SPECIALIST

- Change in Panel Status
  - PCP
  - Open Panel / Closed Panel

- Tax ID Change
  - Effective Date of New Tax ID (required)
  - Previous Tax ID
  - New Tax ID

Sample Change
<table>
<thead>
<tr>
<th>ACTION REQUIRED cont. (Check all that apply)</th>
</tr>
</thead>
</table>

**TERMINATION**

- [ ] Effective Date (required): _____
  - PCP
  - SPECIALIST
  - ANCILLARY

- [ ] Date CalOptima received the termination notice:

  - Exceptions: Review found that the termed specialist is exempt from providing continued access based on the exemption checked below.
    - Provider not available
    - Provider retired
    - Contract not continued
    - Other:
      - Provider Deceased
      - Provider unwilling to accept member / payment terms
      - Termined due to review action

  - PCP Termination: Assign member to new PCP: __________________________
    - Name of new PCP

- [ ] Number of Members Impacted (As of Date Received):
  - Medi-Cal
  - OneCare
  - OneCare Connect

  - Date Member Notice was mailed: If Member Notice has not been sent, please put anticipated date and notify CalOptima if date changes:

- [ ] Number of days’ notice provider gave to MCP:

**ADDRESS/PHONE CHANGE OR ADDITIONAL LOCATION**

- [ ] SERVICE ADDRESS
  - Effective Date (required):
  - Check one: [ ] ADD [ ] TERM
    - Site Telehealth Indicators:
      - Telehealth Only
      - No Telehealth
      - Both Telehealth and In-person

  - Address: __________________________
    - City: __________________________
    - State: __________________________
    - Zip: __________________________

  - Phone Number: __________________________
  - Fax Number: __________________________
  - Office Hours: __________________________
  - After Hours Phone Number: __________________________

- [ ] Office Manager: __________________________
  - E-mail Address: __________________________

- [ ] SERVICE ADDRESS
  - Effective Date (required):
  - Check one: [ ] ADD [ ] TERM
    - Site Telehealth Indicators:
      - Telehealth Only
      - No Telehealth
      - Both Telehealth and In-person

  - Address: __________________________
    - City: __________________________
    - State: __________________________
    - Zip: __________________________

  - Phone Number: __________________________
  - Fax Number: __________________________
  - Office Hours: __________________________
  - After Hours Phone Number: __________________________

- [ ] Office Manager: __________________________
  - E-mail Address: __________________________

**LANGUAGE**

- Languages Spoken by Staff
  - 1. __________________________
  - 2. __________________________
  - 3. __________________________

- Languages Spoken by Provider
  - 1. __________________________
  - 2. __________________________
  - 3. __________________________

**OTHER**

- Comments: __________________________

I certify that the above information is true, accurate and complete to the best of my knowledge and that I am authorized to execute this document on behalf of the applicant. I understand that incorrect or inaccurate information may affect the applicant’s eligibility to receive CalOptima reimbursement and that the applicant must report changes in the above information to the CalOptima Provider Enrollment Unit. I hereby further declare that the applicant listed above and its agents (a) have not been convicted of a criminal offense related to health care in the past seven (7) years, and (b) have never been suspended, excluded or otherwise ineligible to participate in Federal and/or State health care programs based on a mandatory exclusion under 42 U.S.C. § 1396a-7(a).

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**PROVIDER RELATIONS REPRESENTATIVE**

(Please print)

**SIGNATURE**

(Please print)

**DATE**

(Please print)
# CalOptima User Guide

## ADD, CHANGE, AND TERMINATION (ACT) FORM

### Add, Change, and Termination Form

This form must be completed to report any additions, changes, and/or terminations to a provider’s network affiliates. A separate form must be completed for each contracted provider terminated or whose status is being changed.

<table>
<thead>
<tr>
<th>Health Network Name:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Line of Business (Check all that apply)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>☐ Medi-Cal ☐ OneCare ☐ PACE ☐ OneCare Connect</td>
</tr>
</tbody>
</table>

### PROVIDER INFORMATION

<table>
<thead>
<tr>
<th>PROVIDER STATE LICENSE #</th>
<th>PROVIDER TIN #</th>
</tr>
</thead>
<tbody>
<tr>
<td>TYPE: 1 NP (National Provider ID #)</td>
<td>PROVIDER ID</td>
</tr>
<tr>
<td>PROVIDER ID</td>
<td>MEDICARE #</td>
</tr>
<tr>
<td>MEDICAL EFFECTIVE DATE</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PROVIDER NAME (Last)</th>
<th>(First)</th>
<th>(Middle Initial)</th>
</tr>
</thead>
<tbody>
<tr>
<td>PRIMARY TAXONOMY</td>
<td>SECONDARY TAXONOMY</td>
<td></td>
</tr>
<tr>
<td>TERTIARY TAXONOMY</td>
<td>ORDERING, REFERRING, PRESCRIBING (ORP)</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>AREA OF FOCUS</th>
<th>PRIMARY SPECIALTY</th>
<th>SECONDARY SPECIALTY</th>
</tr>
</thead>
</table>

### GROUP NAME

<table>
<thead>
<tr>
<th>GROUP NAME</th>
<th>PROVIDER TEL/HEALTH INDICATORS</th>
</tr>
</thead>
<tbody>
<tr>
<td>GROUP TYPE: 2 NP (National Provider ID #)</td>
<td>GROUP ID</td>
</tr>
<tr>
<td>GROUP ID</td>
<td>GROUP TIN</td>
</tr>
<tr>
<td>SERVICE ADDRESS FOR AFFILIATION (See Page 2 for address changes and additional locations)</td>
<td>CITY</td>
</tr>
<tr>
<td>STATE</td>
<td>ZIP</td>
</tr>
<tr>
<td>REMIT ADDRESS</td>
<td>CITY</td>
</tr>
<tr>
<td>STATE</td>
<td>ZIP</td>
</tr>
<tr>
<td>OFFICE MANAGER</td>
<td>PHONE NUMBER</td>
</tr>
<tr>
<td>FAX NUMBER</td>
<td>PUBLIC E-MAIL ADDRESS</td>
</tr>
</tbody>
</table>

### HOSPITAL / FACILITY AFFILIATIONS AND ADMITTING PRIVILEGES

1.  |  |  |
2.  |  |  |
3.  |  |  |

<table>
<thead>
<tr>
<th></th>
<th>☐ EMAIL ATTESTATION ON FILE</th>
</tr>
</thead>
</table>

### ACTION REQUIRED (Check all that apply)

|  |  |  |
|--------------------------|--------------------------|

| NEW ADD OR AFFILIATION |  |  |
|------------------------|------------------------|

| PROVIDER TYPE |  |  |
|---------------|------------------------|

| CHANGE IN PANEL STATUS |  |  |
|------------------------|------------------------|

| PROVIDER TYPE |  |  |
|---------------|------------------------|

| TAX I.D. CHANGE |  |  |
|----------------|------------------------|

### REQUIREMENTS: The PR rep must complete this form, including credentialing information, for each provider being added as a provider affiliate. In addition, a copy of the notification and signature page from the provider’s contract and a W-9 form must be attached. If copies are not attached, the form will be rejected by CMS and returned to the PR rep.

Effective Date (required): Date Credentialing Completed (within the last 3 years): Current Facility Site Review Date (within the last 3 years):

| PROVIDER TYPE |  |  |
|---------------|------------------------|

### REQUIREMENTS: Panel changes are effective the date of processing.

| PROVIDER TYPE |  |  |
|---------------|------------------------|

### REQUIREMENTS: The health network must attach a copy of the provider notification indicating the change of tax ID and a new W-9 form.

Effective Date of New Tax I.D. (required): Previous Tax I.D.:

New Tax I.D.:
# ADD, CHANGE, AND TERMINATION (ACT) FORM

**ACTION REQUIRED cont. (Check all that apply)**

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Effective Date</td>
<td>Required for all sections.</td>
</tr>
<tr>
<td>PCP</td>
<td>[ ]</td>
</tr>
<tr>
<td>Specialist</td>
<td>[ ]</td>
</tr>
<tr>
<td>Ancillary</td>
<td>[ ]</td>
</tr>
</tbody>
</table>

**TERMINATION**

- Date CalOptima received the termination notice:
- Exceptions: Review found that the termed specialist is exempt from providing continued access based on the exemption checked below.
  - Provider not available
  - Provider Retired
  - Contract not continued
  - Other: __________

**PCP Termination**

- Assign member to new PCP: __________
- Name of new PCP: __________

**Number of Members Impacted**

- As of Date Received: [ ] Medi-Cal [ ] OneCare [ ] OneCare Connect

**Date Member Notice was mailed**

- If Member Notice has not been sent, please put anticipated date and notify CalOptima if date changes:

**Number of days’ notice provider gave to MCP:**

**ADDRESS/PHONE CHANGE OR ADDITIONAL LOCATION**

- Effective Date (required):
- Site Telehealth Indicators:
  - Both Telehealth and In-person
  - No Telehealth

**SERVICE ADDRESS**

- Check one: [ ] ADD [ ] TERM
- Address: __________
- City: __________
- State: __________
- Zip: __________

**Phone Number**

- Fax Number: __________
- Office Hours: __________
- After Hours Phone Number: __________

**Office Manager**

- E-mail Address: __________

**LANGUAGE**

- Languages Spoken by Staff:
  1. __________
  2. __________
  3. __________

- Languages Spoken by Provider:
  1. __________
  2. __________
  3. __________

**OTHER**

- Comments:
  1. __________
  2. __________
  3. __________

**I certify that the above information is true, accurate and complete to the best of my knowledge and that I am authorized to execute this document on behalf of the applicant. I understand that incorrect or inaccurate information may affect the applicant’s eligibility to receive CalOptima reimbursement and that the applicant must report changes in the above information to the CalOptima Provider Enrollment Unit. I hereby further declare that the applicant listed above and its agents (a) have not been convicted of a criminal offense related to health care in the past seven (7) years; and (b) have never been suspended, excluded or otherwise ineligible to participate in Federal and/or State health care programs based on a mandatory exclusion under 42 U.S.C. § 1396a-7(a).**

**PROVIDER RELATIONS REPRESENTATIVE**

- (Please print)

**SIGNATURE**

- (Please print)

**DATE**
CalOptima requests use of the email header naming convention reflected below to ensure compliance with turn-around guidelines. Please use the headers below; do not add “Urgent” or deviate from the headers below.

### Naming Convention for Email Subject Headers

#### Provider

```
Submission Date | Provider Type | Request Type | Health Network | Provider Last Name | Provider First Name | License # | Line of Business
```

**11-1-18 ACT – PCP Term Monarch Moore, Hezekiah N MD (A12345) (Medi-Cal, OC, OCC)**

**Submission Email Subject Header Naming Convention:**
- Submission Date: Date form is submitted
- Provider Type: PCP, SPC, MIDLEVEL, ANC
- Request Type: Add, Change, Term, CAP (Corrective Action Plan)
- Health Network Name: Provider Health Network Affiliation
- Provider Last Name: Last name of provider based on State license
- Provider First Name: First Name of provider based on State license
- License #: State license number
- Line of Business: MC = Medi-Cal, OC = OneCare, OCC = OneCare Connect

#### Facility

```
Submission Date | Request Type | Health Network | Facility Name | Facility NPI | Line of Business
```

**11-1-18 ACT – Demo Change CCN – Kindred Hospital Santa Ana (1234567891) (Medi-Cal, OC, OCC)**

**Facility Email Subject Header Naming Convention:**
- Submission Date: Date form is submitted
- Request Type: Add, Change, Term, CAP (Corrective Action Plan)
- Health Network Name: Facility Health Network Affiliation
- Facility Name: Facility Name as reflected on Agreement
- Facility NPI: Facility NPI
- Line of Business: MC = Medi-Cal, OC = OneCare, OCC = OneCare Connect

#### Group

```
Submission Date | Request Type | Health Network | Group Name | Tax ID# | NPI# | Line of Business
```

**11-1-18 ACT – Tax Change AltaMed – Fairview Medical Group (99-99999999) (1234567897) (Medi-Cal, OC, OCC)**

**Group Email Subject Header Naming Convention:**
- Submission Date: Date form is submitted
- Request Type: Add, Change, Term, CAP (Corrective Action Plan)
- Health Network Name: Provider’s Health Network Affiliation
- Group Name: Name of group as reflected on Agreement
- Tax-ID: Group Tax ID on accompanying W-9
- NPI #: Type 2 NPI
### Definitions

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Health Network Name</strong></td>
<td>Health network group name</td>
</tr>
<tr>
<td><strong>Line of Business</strong></td>
<td>The program/product code the practitioner affiliates with CalOptima at the practice location. Line of business codes include: MC = Medi-Cal; OC = OneCare; OCC = OCC; PACE = PACE. If practitioner has more than one program, insert additional line of business records (rows) for each program.</td>
</tr>
<tr>
<td><strong>California License Number</strong></td>
<td>California license number of the practitioner. Catenate the license type letter (NP, CNM, and PA for mid-level; A, C, G, and 20A for MD and DO; E for DPM) and license number together and no space in between.</td>
</tr>
<tr>
<td><strong>Provider TIN</strong></td>
<td>The individual federal tax ID of the practitioner. Note: it is NOT a provider group, IPA or location's TIN. Numbers only - no space and no special characters.</td>
</tr>
<tr>
<td><strong>Type 1 NPI</strong></td>
<td>National provider identifier of the practitioner (NPI type 1, 10 digits)</td>
</tr>
<tr>
<td><strong>Provider ID</strong></td>
<td>The individual identification number assigned by CalOptima to be used for existing providers for demographic changes and terminations (9 digits = solo practitioner; 12 digits = affiliated to a group)</td>
</tr>
<tr>
<td><strong>Medicare Number</strong></td>
<td>CMS Certification Number is used to verify that a provider has been Medicare/Medicaid certified and for what type of services. Formerly it is known as 1) OSCAR provider number, 2) Medicare Identification Number, or 3) Medicare/Medicaid Identification Number. Reference: CMS Manual System, Pub 100-07 State Operations Provider Certification.</td>
</tr>
<tr>
<td><strong>Medi-Cal Effective Date</strong></td>
<td>Effective date the provider received a Medicaid provider number.</td>
</tr>
<tr>
<td><strong>Provider Last Name</strong></td>
<td>Full last name attached to the practitioner's professional license issued by the State of California. For practitioners not subject to state licensure, such as certain qualified autism service providers, it means the last name appearing on the certification by a national entity.</td>
</tr>
<tr>
<td><strong>Provider First Name</strong></td>
<td>Full first name attached to the practitioner's professional license issued by the State of California. For practitioners not subject to state licensure, such as certain qualified autism service providers, it means the first name appearing on the certification by a national entity.</td>
</tr>
<tr>
<td><strong>Provider Middle Name</strong></td>
<td>Full middle name attached to the practitioner's professional license issued by the State of California. For practitioners not subject to state licensure, such as certain qualified autism service providers, it means the middle name appearing on the certification by a national entity.</td>
</tr>
<tr>
<td><strong>Taxonomy (Primary, Secondary, Tertiary)</strong></td>
<td>The taxonomy code of the specialty for which the practitioner has. Please refer to the taxonomy crosswalk provided by CalOptima.</td>
</tr>
<tr>
<td><strong>Facility Physical Accessibility Compliance</strong></td>
<td>Meets facility American Disability Act (ADA) handicapped compliance.</td>
</tr>
<tr>
<td><strong>Ordering, Referring, Prescribing (ORP)</strong></td>
<td>State or Federal regulated certification for providers who order, refer or prescribe.</td>
</tr>
<tr>
<td><strong>Area of Focus</strong></td>
<td>The specific focus of the specialty for which the practitioner has.</td>
</tr>
<tr>
<td><strong>Primary Specialty</strong></td>
<td>The primary specialty for which the practitioner is contracted to provide services at the location. 1) When providers practice at multiple sites, they may have different primary and secondary specialties for each site based on the contract.</td>
</tr>
</tbody>
</table>
### ADD, CHANGE, AND TERMINATION (ACT) FORM

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>SECONDARY SPECIALTY</strong></td>
<td>The secondary specialty for which the practitioner is contracted to provide services at the location. When providers practice at multiple sites, they may have different primary and secondary specialties for each site based on the contract.</td>
</tr>
<tr>
<td><strong>GROUP NAME</strong></td>
<td>Full name of Medical Group practitioner is affiliated with based on contract.</td>
</tr>
<tr>
<td><strong>GROUP/TYPE 2 NPI</strong></td>
<td>National provider identifier of the medical group (NPI type 2, 10 digits)</td>
</tr>
<tr>
<td><strong>GROUP ID</strong></td>
<td>The identification number assigned by CalOptima to be used for existing medical groups for demographic changes and terminations (9 digits)</td>
</tr>
<tr>
<td><strong>GROUP TIN</strong></td>
<td>The group federal tax ID of the practitioner. Numbers only - no space and no special characters.</td>
</tr>
<tr>
<td><strong>SERVICE LOCATION STREET</strong></td>
<td>USPS CASS-certified delivery address street names and their ranges at the practice location. Must use USPS postal addressing standard (Publication 28). No special characters. No punctuation unless a decimal in number (39.2 RD), fractional addresses (39 1/2 RD) or hyphenated addresses (39-3 RD). A space between secondary designator and range: APT = Apartment; BLDG = Building; FL = Floor; STE = Suite; UNIT = Unit; RM = Room; DEPT = Department.</td>
</tr>
<tr>
<td><strong>SERVICE LOCATION CITY</strong></td>
<td>City where the practice location is located. Must be USPS CASS-certified and use USPS postal addressing standard (Publication28).</td>
</tr>
<tr>
<td><strong>SERVICE LOCATION COUNTY</strong></td>
<td>County where the practice is located.</td>
</tr>
<tr>
<td><strong>SERVICE LOCATION STATE</strong></td>
<td>State where the practice is located. Must be USPS CASS-certified and use USPS postal addressing standard (Publication28).</td>
</tr>
<tr>
<td><strong>SERVICE LOCATION ZIP</strong></td>
<td>Zip code in which the practice is located (5 digits). Must be USPS CASS-certified and use USPS postal addressing standard (Publication28).</td>
</tr>
<tr>
<td><strong>SECONDARY SPECIALTY</strong></td>
<td>The secondary specialty for which the practitioner is contracted to provide services at the location. When providers practice at multiple sites, they may have different primary and secondary specialties for each site based on the contract.</td>
</tr>
<tr>
<td><strong>REMIT STREET</strong></td>
<td>USPS CASS-certified pay-to address street names, secondary address unit designators and their ranges for this practice location. Must use USPS postal addressing standard (Publication 28). No special characters. No punctuation unless a decimal in number (39.2 RD), fractional addresses (39 1/2 RD) or hyphenated addresses (39-3 RD). A space between secondary designator and range: APT = Apartment; BLDG = Building; FL = Floor; STE = Suite; UNIT = Unit; RM = Room; DEPT = Department.</td>
</tr>
<tr>
<td><strong>REMIT CITY</strong></td>
<td>City where the pay-to is located. Must be USPS CASS-certified and use USPS postal addressing standard (Publication28).</td>
</tr>
<tr>
<td><strong>REMIT STATE</strong></td>
<td>State where the pay-to is located. Must be USPS CASS-certified and use USPS postal addressing standard (Publication28).</td>
</tr>
<tr>
<td><strong>REMIT ZIP</strong></td>
<td>Zip code in which the pay-to is located (5 digits). Must be USPS CASS-certified and use USPS postal addressing standard (Publication28).</td>
</tr>
<tr>
<td><strong>OFFICE MANAGER</strong></td>
<td>Name of the contact person at the practice location.</td>
</tr>
<tr>
<td><strong>PHONE NUMBER</strong></td>
<td>Phone number at practice location. 10-digit number only and no space or special character.</td>
</tr>
<tr>
<td><strong>FAX NUMBER</strong></td>
<td>Fax number at practice location. 10-digit number only and no space or special character.</td>
</tr>
<tr>
<td><strong>PUBLIC EMAIL</strong></td>
<td>Email address the practitioner would like to be published on the directory for inquiries from CalOptima members. Note: it is NOT site contact person's email.</td>
</tr>
<tr>
<td><strong>ADMINISTRATION EMAIL ADDRESS</strong></td>
<td>Email address the practitioner uses for business correspondence with CalOptima only. Note: it is NOT site contact person's email. It is internal use between CalOptima and practitioner only.</td>
</tr>
<tr>
<td><strong>WEBSITE URL ADDRESS</strong></td>
<td>The webpage or other online resource for the practice location. Use complete URL syntax including scheme, 2 slashes, authority part and path, with optional query and fragment.</td>
</tr>
<tr>
<td>------------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>SPECIAL SERVICES</strong></td>
<td>Check all that apply: CCS, CHDP, CPSP</td>
</tr>
<tr>
<td><strong>HOSPITAL / FACILITY AFFILIATIONS ADMITTING PRIV</strong></td>
<td>The name of CalOptima contracted hospital where the practitioner him/herself is on staff and/or having admitting privilege. Type of privileges includes: NONE, ACTIVE, ASSOCIATE STAFF, HONORARY, CONSULTANT, COURTESY, LIMITED, PROVISIONAL, SENIOR ATTENDING, SURGICAL, SUSPENDED.</td>
</tr>
<tr>
<td><strong>ATTESTATION</strong></td>
<td>Yes = HN has received a provider attestation; No = HN has not received a provider attestation. Note it won't be published in provider directory now, but by providing the public email, the provider acknowledges and agrees that the email is for patient communications, regularly monitored, maintained in manner consistent with state and federal health privacy laws, including Health Insurance Portability and Accountability Act (HIPAA) and Confidentiality of Medical Information Act (CMIA).</td>
</tr>
<tr>
<td><strong>ACCEPTING NEW PATIENTS</strong></td>
<td>Accepting new patients; No = Not accepting new patients</td>
</tr>
<tr>
<td><strong>ACCEPTING EXISTING PATIENTS</strong></td>
<td>Accepting existing patients; No = Not accepting existing patients</td>
</tr>
<tr>
<td><strong>ACCEPTING THROUGH REFERRAL</strong></td>
<td>Accepting through referral; No = Not accepting through referral</td>
</tr>
<tr>
<td><strong>ACCEPTING THROUGH HOSPITAL FACILITY</strong></td>
<td>Accepting through hospital facility; No = Not accepting through referral</td>
</tr>
<tr>
<td><strong>NOT ACCEPTING NEW PATIENTS</strong></td>
<td>Not accepting new patients</td>
</tr>
<tr>
<td><strong>PANEL STATUS</strong></td>
<td>The providers panel status is &quot;Open&quot; or &quot;Closed&quot;.</td>
</tr>
<tr>
<td><strong>OFFICE HOUR SUNDAY</strong></td>
<td>Office hours of the practice location on Sunday. &quot;CLOSED&quot; if not open. Format is &quot;HH:MI-HH:MI&quot;, 11 digits exact and no space. HH is between 00 and 23. Ignore lunch closure. If it opens 8:30am-12pm and 1pm-5pm, then put &quot;08:30-17:00&quot;.</td>
</tr>
<tr>
<td><strong>OFFICE HOUR MONDAY</strong></td>
<td>Office hours of the practice location on Monday. &quot;CLOSED&quot; if not open. Format is &quot;HH:MI-HH:MI&quot;, 11 digits exact and no space. HH is between 00 and 23. Ignore lunch closure. If it opens 8:30am-12pm and 1pm-5pm, then put &quot;08:30-17:00&quot;.</td>
</tr>
<tr>
<td><strong>OFFICE HOUR TUESDAY</strong></td>
<td>Office hours of the practice location on Tuesday. &quot;CLOSED&quot; if not open. Format is &quot;HH:MI-HH:MI&quot;, 11 digits exact and no space. HH is between 00 and 23. Ignore lunch closure. If it opens 8:30am-12pm and 1pm-5pm, then put &quot;08:30-17:00&quot;.</td>
</tr>
<tr>
<td><strong>OFFICE HOUR WEDNESDAY</strong></td>
<td>Office hours of the practice location on Wednesday. &quot;CLOSED&quot; if not open. Format is &quot;HH:MI-HH:MI&quot;, 11 digits exact and no space. HH is between 00 and 23. Ignore lunch closure. If it opens 8:30am-12pm and 1pm-5pm, then put &quot;08:30-17:00&quot;.</td>
</tr>
<tr>
<td><strong>OFFICE HOUR THURSDAY</strong></td>
<td>Office hours of the practice location on Thursday. &quot;CLOSED&quot; if not open. Format is &quot;HH:MI-HH:MI&quot;, 11 digits exact and no space. HH is between 00 and 23. Ignore lunch closure. If it opens 8:30am-12pm and 1pm-5pm, then put &quot;08:30-17:00&quot;.</td>
</tr>
<tr>
<td><strong>OFFICE HOUR FRIDAY</strong></td>
<td>Office hours of the practice location on Friday. &quot;CLOSED&quot; if not open. Format is &quot;HH:MI-HH:MI&quot;, 11 digits exact and no space. HH is between 00 and 23. Ignore lunch closure. If it opens 8:30am-12pm and 1pm-5pm, then put &quot;08:30-17:00&quot;.</td>
</tr>
<tr>
<td><strong>OFFICE HOUR SATURDAY</strong></td>
<td>Office hours of the practice location on Saturday. &quot;CLOSED&quot; if not open. Format is &quot;HH:MI-HH:MI&quot;, 11 digits exact and no space. HH is between 00 and 23. Ignore lunch closure. If it opens 8:30am-12pm and 1pm-5pm, then put &quot;08:30-17:00&quot;.</td>
</tr>
<tr>
<td><strong>SERVICE LOCATION PHONE AFTER-HOURS</strong></td>
<td>Phone number at practice location after hours in case of emergency or urgency. 10-digit number only and no space or special character.</td>
</tr>
<tr>
<td><strong>STAFF LANGUAGE</strong></td>
<td>The language spoken by office staff (not providers) at practice location. Use Language tab.</td>
</tr>
</tbody>
</table>
**PRACTITIONER LANGUAGE**  | The language practitioner speaks. Use Language tab.  
**MEMBER AGE MIN**  | Use comments section: CalOptima member's minimum age that is allowed at the practice location based on provider's contracted specialty. Age is presented in year and no limit = 0.  
**MEMBER AGE MAX**  | Use comments section: CalOptima member's maximum age that is allowed at the practice location based on provider's contracted specialty. Age is presented in year and no limit = 150.  
**GENDER RESTRICTION**  | Use comments section: If the service at the practice location is only accessible to specific gender of CalOptima member. F = female member only; M = male member only; NR = no restriction.  
**TELEHEALTH SITE INDICATORS**  | Site indicator: Telehealth Only, No Telehealth, or Both Telehealth and In-Person. Use Telehealth Tab.