# 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 # | 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 E-MAIL ADDRESS |
| ADMINISTRATION EMAIL ADDRESS | WEBSITE URL ADDRESS | SPECIAL SERVICES ☐ CCS ☐ CHDP ☐ CPSP | |

HOSPITAL / FACILITY AFFILIATIONS AND ADMITTING PRIVLEGES

| 1. _____ | 2. _____ | 3. _____ |
|---|---|---|
| ☐ NONE ☐ ACTIVE ☐ ASSOCIATE STAFF | ☐ NONE ☐ ACTIVE ☐ ASSOCIATE STAFF | ☐ NONE ☐ ACTIVE ☐ ASSOCIATE STAFF |
| ☐ HONORARY ☐ CONSULTANT | ☐ HONORARY ☐ CONSULTANT | ☐ HONORARY ☐ CONSULTANT |
| ☐ COURTESY ☐ LIMITED ☐ PROVISIONAL | ☐ COURTESY ☐ LIMITED ☐ PROVISIONAL | ☐ COURTESY ☐ LIMITED ☐ PROVISIONAL |
| ☐ SENIOR ATTENDING ☐ SURGICAL | ☐ SENIOR ATTENDING ☐ SURGICAL | ☐ SENIOR ATTENDING ☐ SURGICAL |
| ☐ SUSPENDED | ☐ SUSPENDED | ☐ SUSPENDED |

☐ EMAIL ATTESTATION ON FILE

## *ACTION REQUIRED (Check all that apply)*

### ☐ NEW ADD OR AFFILIATION

**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 recitation and signature pages from the provider contract and a W-9 form** must be attached. If copies are not attached, the form will be rejected by PDMS and returned to the PR Rep.

| Effective Date **(required)**: | Date Credentialing Completed (within the last 3 years) | Current Facility Site Review Date (within last 3 years) |
|---|---|---|
| PROVIDER TYPE | ☐ **ANCILLARY/ALLIED HEALTH**<br>☐ **PCP**<br>☐ **SPECIALIST** | ☐ **Open Panel /** ☐ **Closed Panel**<br>☐ Accepting new patients<br>☐ Accepting existing patients<br>☐ Accepting new patients through referral<br>☐ Accepting new patients through a hospital/facility<br>☐ Not accepting new patients |

### ☐ CHANGE IN PANEL STATUS

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

| PROVIDER TYPE (If applicable, check both) | | |
|---|---|---|
| | ☐ **PCP** | ☐ **Open Panel /** ☐ **Closed Panel**<br>☐ Accepting new patients<br>☐ Accepting existing patients<br>☐ Accepting new patients through referral<br>☐ Accepting new patients through a hospital/facility<br>☐ Not accepting new patients |
| | ☐ **SPECIALIST** | |

### ☐ 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. |
|---|---|---|
| | | |

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

### ☐ TERMINATION

**REQUIREMENTS:** Complete this form for each provider being terminated from its provider network affiliates. If the termination is requested by the provider, a copy of the request from the provider must be attached. If a copy is not attached, the form will be rejected by PDMS and returned to the PR Rep.

| 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
- ☐ Termed 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

**REQUIREMENTS:** For all address changes, select [TERM] to remove an old/prior address, and select [ADD] to add the new location. For additional location, select [ADD] to add the additional location. If PCP site, a Facility Site Review is required. A copy of documentation submitted by the provider AND a new W-9 form must be attached, if applicable. Note: The form contains three (3) address sections, allowing multiple changes to be entered for one provider on the same form.

| **SERVICE ADDRESS**<br>**Check one: [ ] ADD [ ] TERM** | Effective Date (required): | SITE TELEHEATH INDICATORS<br>☐ Telehealth Only ☐ No Telehealth<br>☐ 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**<br>**Check one: [ ] ADD [ ] TERM** | Effective Date (required): | SITE TELEHEATH INDICATORS<br>☐ Telehealth Only ☐ No Telehealth<br>☐ 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

2. _____ 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).

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