Provider Change Request Form

Group/Organization Name: ______________________________

Group/Organization National Practitioner Provider Number(NPI): ____________________

Please check the category to indicate the provider change:

☐ **1. Organization or Group Provider Name Change**
(Please submit Amendment Letter)

Original	Changed To (New)
______________________	______________________

☐ **2. Change of Medicaid Number:**
(Please submit Amendment Letter and a copy of W9)

Original	Changed To (New)
______________________	______________________

☐ **3. Change of Phone Number(s):**

	Original Number	Changed To (New)
Telephone Number:	______________	______________________
Fax Number:	______________	______________________

☐

	Original Number	Changed To (New
Pay to Address:	______________	______________________
	______________	______________________
	______________	______________________
Mailing Address:	______________	______________________
	______________	______________________
	______________	______________________
Tax Address:		
	______________	______________________
	______________	______________________
	______________	______________________

☐ **5. Adding a new location:**

(Please fill up Additional Practice Addendum for each provider for the new location.)

ADDITIONAL PRACTICE ADDENDUM

Please complete the following for each company or location in which you practice. You may copy additional sheets if necessary.

Individual provider Name: ______________________ **License Type:** __________

Individual Medicaid Number/IHCP number: __________ **NPI:** __________

Please provide your pay to address below:

Name: __________ **Address:** __________

City: __________ **State:** ______ **Zip Code+4:** ______ - ______ **County:** __________

Email Address: __________

Billing Tax Identification: __________

Group Medicaid# (IHCP#): __________ **Loc:** ______ **Group NPI:** __________

Telephone Number: __________ **Fax Number:** __________

Please check one: **Are you an Employee?** ______ **Or Contractor?** ______

Please provide your physical address/Medicaid Service Location below:

Name: __________ **Address:** __________

City: __________ **State:** ______ **Zip Code+4** ______ - ______ **County:** __________

Phone: __________ **Fax:** __________

Clinic hours at this location:

Mon. ______ **Tue.** ______ **Wed.** ______ **Thurs.** ______ **Fri.** ______ **Sat.** ______ **Sun.** ______

Individual Provider weekly hours at this location:

Mon. ______ **Tue.** ______ **Wed.** ______ **Thurs.** ______ **Fri.** ______ **Sat.** ______ **Sun.** ______

Is this location near public transportation lines? ______

Are facilities at this site ADA accessible? ______

What is the size of your current average case load? ______ **# of Consumers** ______

What is the average number of "intake" times (open slots for new consumers) available per month? ______

Please provide your mailing address below.

Name: __________ **Address:** __________

City: __________ **State:** ______ **Zip Code:** ______ - ______ **County:** __________

Phone: __________ **Fax:** __________

Please provider your address for tax purposes below:

Name: __________ **Address:** __________

City: __________ **State:** ______ **Zip Code:** ______ - ______ **County:** __________

Age groups treated by this provider.

________	**0-6**	________	**13-17**	________	**65+**
________	**7-12**	________	**18-64**	________	**All Ages**

Are you accepting new patients: **Yes** ________ **No** ________

Access Information

I. From the time of call to your practice, what is the average amount of time it takes for consumers to be Seen for their first routine appointment? ____________ Days (Please use data for the last 3 months)

A. Routine Appointments:
Contact Name(s): ________________________________
Phone Number(s) ________________________________

Please write in the steps for routine access in the space below:

____
____
____

II. Does your practice have 24 hour life threatening emergency coverage? ❒Yes ❒No
If yes, please describe coverage:

____
____
____

A. Crisis Appointments:
Contact Name(s): ________________________________
Phone Number(S) ________________________________

Please write in the steps for crisis access in the space below:

____
____
____

III. Does your practice offer urgent care appointments within 48 hours? ❒Yes ❒No

A. Urgent Appointments
Contact Name(s): ________________________________
Phone Number(s): ________________________________

Please write in the steps for crisis access in the space below:

____
____
____

IV. Do all locations where you practice have handicapped accessibility? Yes ____ No ____
If not, please attach an explanation.

V. Do all locations where you practice have well lit waiting rooms and treatment rooms? Yes ____ No ____

VI. Do all locations where you practice have adequate seating? Yes ____ No ____

VII. Do all locations where you practice have posted office hours? Yes ____ No ____

Individual Provider Area of Specialty and Treatment Modalities/Approaches

Specialty	Check Specialization	Treatment Modalities/Approaches	Check Modalities/ Approaches
Addictive Disorders	☐	12 Step/Recovery Model	☐
ADHD	☐	Behavior Modification	☐
Adjustment Disorders	☐	Biofeedback	☐
Anxiety Disorders	☐	Biologic/Medical	☐
Attachment Disorders	☐	Brief Solution Focused Therapy	☐
Autism	☐	CBT	☐
Child Abuse/Neglect	☐	Client Centered Therapy	☐
Child and Adolescent Clinical Syndromes	☐	Dialectical Behavioral Therapy (DBT)	☐
Chronic Pain	☐	EMDR	☐
Compulsive Behavioral Disorders	☐	Family Systems	☐
Compulsive/Obsessive Disorders	☐	Hypnosis	☐
Critical Incident Stress Debriefing	☐	Motivational Interviewing	☐
Depressive Disorders	☐	NLP	☐
Disruptive Behavior Disorder	☐	Psychoanalytic	☐
Dissociative Disorders	☐	Rationale Emotive Therapy	☐
Domestic Violence	☐	Trauma Informed Care	☐
Dual Diagnosis	☐	____________	☐
Eating Disorders	☐	Other ____________	☐
Faith based counseling	☐	____________	☐
Functional Deficits	☐		
Gay/Lesbian Issues	☐		
Geriatrics	☐		
Hyperactivity/Behavior Issues	☐		
Medical Issues	☐		
Men's Issues	☐		
Mood Disorders	☐		
Neuropsychology	☐		
Oppositional Defiant Disorder	☐		
Personality Disorders	☐		
Pervasive Developmental Disorders	☐		
Psychological Testing	☐		
Psychopharmacology	☐		
Psychosexual Issues/Gender Identification	☐		
Psychosomatic/Somatoform	☐		
Psychotic Disorders	☐		
PTSD/Acute Stress	☐		
Reactive Attachment Disorder	☐		
Relationship Therapies Including Divorce	☐		
Schizophrenia	☐		
Sexual Abuse (Child)	☐		
Sexual Abuse (Current)	☐		
Substance Use Disorders	☐		
Women's Issues	☐		
____________	☐		
Other ____________	☐		
____________	☐		

☐ 6. **Change of Email Address:**

Original	Changed To (New)

☐ 7. **Individual Provider Name Change**
(e.g. Provider's name from Maiden to Married Name, etc.)

Original	Changed To (New)

☐ 8. **Provider has left practice:**
(Please name provider(s)here who are leaving)

Provider Name	Effective Date of when provider left or leaving

☐ 9. **Intent to Terminate Contract**

(please list which specific contract that you intend to term here)	(please list the effective date of termination)

☐ 10. **Change Professional Licensure:** (e.g. LMFT to HSPP)

Original License	New License	Provider Name	Effective Date

☐ 11. **Other**

I attest that the aforementioned changes are accurate to the best of my ability.

Printed Name: ______________________________

Signature: ______________________________

Title or Relationship to Group/Organization:

____

Phone Number: ______________________________

Email Address: ______________________________

Date: ______________________________

Once you have completed this form, you can either PDF it directly to InteCare; mail it; fax it; and/or scan and email it to the InteCare office.

For faxing: please fax to: 317-472-7399

For email: please email to: jmaxwellcoker@intecare.org

To Mail: Mail to: ATTN: Julie Maxwell-Coker
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