



PROVIDER INFORMATION UPDATE FORM

This form will notify BHSD & VHP of any changes to your agency/clinic provider information.

*DO NOT use this form if submitting a request for multiple providers.
 For multiple providers, use the bulk request form. [Click here to download bulk form](#)
 For a single provider update, use this form.*

***Required fields (if not completed, this form will be returned for additional required details.)**

- *Today's Date: Mental Health SUTS Both
- *Agency Name: Submitter Phone #:
- *Submitter Name: County CCP FFS
- *Submitter Email Address:

Provider Information

- *First Name: *Last Name:
- *NPI#: Avatar Profile ID # (if known):

Please Select from the List of Requests Below:

Clinic Location Update Request

- Current Address: Current Location NPI#:
- New Location Address: New Location NPI#:
- Effective Date of New Location:

Credential Update Request

- Current Credential: Current Taxonomy:
- Updated Credential: Updated Taxonomy:
- Effective Date of Updated Credential:
- *Provide supporting documentation for updated credential.
 Reference this list to confirm credential type. [CLICK HERE TO DOWNLOAD LIST OF CPT CODES](#)*

License/Registration/Certification Renewal Request

- Current Credential: License/Registration/Certification Number:
- New Expiration Date:
- *Provide supporting documentation for renewal.*

Provider Profile Update Request

- *If more than one requested change, itemize up to three (3) changes below.*

Request #1: Effective Date:
Changing From: Changing To:
Comments:

Request #2: Effective Date:
Changing From: Changing To:
Comments:

Trainee Supervisor Change

OLD Supervisor Name: OLD Supervisor NPI:
OLD Supervisor Credential: OLD Effective Date:

NEW Supervisor Name: NEW Supervisor NPI:
NEW Supervisor Credential: NEW Effective Date:

Termination/Disassociation/Leave Of Absence (LOA)

Term Reason:
Effective Date of when Provider Leaves/Left Agency:

If Leave of Absence, Anticipated Start and Return Date:
If Returning from Leave of Absence, Return Date:
Comments:

Other: Report Issues Not Listed Above

Provide Explanation:

Send Completed Form to BHProviderUpdates@hhs.sccgov.org
(Do not encrypt emails. When encrypted emails are received, they cannot be viewed)

Include the request in the subject of the email.
(e.g. Subject: Credential Update Request)