OPTUM®

OPTUMHealth™
Behavioral Solutions of California

Agency / Community Mental Health Center / Clinic
Clinician Roster Update Form

Throughout this document, the term "Agency" is used to refer to Agencies, Community Mental Health Centers, and Clinics.

To ensure proper maintenance of your independently licensed clinician roster, complete and submit this form as staffing changes occur. Form may also be used to confirm that no changes to the roster are required at this time. Non-licensed staff should not be included on this report. Only include independently licensed staff who will submit claims. To ensure clarity, please complete this form electronically rather than in handwriting, if possible. Multiple forms can be submitted, if necessary.

Section A: Agency Information / Update Type

Name of Agency: _____

Update Type:
- ☐ Add, delete or update Clinician data
- ☐ Confirm that NO CHANGES are required to Clinician data

Tax Identification Number (TIN): _____

All changes listed on this form must correspond to the TIN shown above. If the Agency has more than one TIN, please submit a separate form for each TIN.

Section B: Deletions List all independently licensed clinicians who have left the Agency

Last Name	First Name	Individual NPI	Effective Date of Deletion

Section C: Additions / Updates

☐ Check here if new clinician(s) is being added or if existing clinician data requires updating. Complete a copy of page 2 for each clinician being added or updated.

Section D: Acknowledgement by Administrator / Roster Contact

Roster Contact (printed name)	Signature (or email address)	Date

Fax or email completed form to Optum/OptumHealth Behavioral Solutions of California Network Management Contact information at *providerexpress.com*

United Behavioral Health operating under the brand Optum
U..S. Behavioral Health Plan, California, doing business as OptumHealth Behavioral Solutions of California

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Section C (continued): Complete one page for each new or updated independently licensed clinician

☐ Add new clinician — Effective Date of Addition: _____

☐ Update existing clinician data — Effective Date of Change: _____

Last Name: _____

First Name: _____

Middle Initial: _____

License Level (MD, LP, LCSW, APRN, etc.): _____

License Number: _____

Prescriptive Authority? ☐ Yes ☐ No

Gender: ☐ Male ☐ Female

Individual NPI: _____

Taxonomy: _____

SSN: _____

Date of Birth: _____

Individual Medicare ID: _____

Individual Medicaid ID: _____

Medicaid Issue State: _____

Medicaid Issue Date: _____

Primary Practice Location (cannot contain a PO Box)**:**

Primary Practice Address	City	State	Zip	Site Conditions	Availability
				☐ Evening Apps ☐ Weekend Appts ☐ Public Trans Access ☐ Wheelchair Access	☐ Inpatient or In-Home Only ☐ Accepting New Patients
Phone	**Secure Fax**	☐ **No Secure Fax**			

Additional Practice Location(s) (cannot contain a PO Box):

	Add	Delete	Practice Address	City	State	Zip	Site Conditions	Availability
1	☐	☐					☐ Evening Apps ☐ Weekend Appts ☐ Public Trans Access ☐ Wheelchair Access	☐ Inpatient or In-Home Only ☐ Accepting New Patients
			Phone	**Secure Fax**	☐ **No Secure Fax**			
2	☐	☐					☐ Evening Apps ☐ Weekend Appts ☐ Public Trans Access ☐ Wheelchair Access	☐ Inpatient or In-Home Only ☐ Accepting New Patients
			Phone	**Secure Fax**	☐ **No Secure Fax**			
3	☐	☐					☐ Evening Apps ☐ Weekend Appts ☐ Public Trans Access ☐ Wheelchair Access	☐ Inpatient or In-Home Only ☐ Accepting New Patients
			Phone	**Secure Fax**	☐ **No Secure Fax**			

Agency / Community Mental Health Center / Clinic – Clinician Roster Update Form (Additional page 2, if needed)

Section C (continued): Complete one page for each new or updated independently licensed clinician

☐ Add new clinician — Effective Date of Addition: _____

☐ Update existing clinician data — Effective Date of Change: _____

Last Name: _____
First Name: _____
Middle Initial: _____
License Level (MD, LP, LCSW, APRN, etc.): _____
License Number: _____
Prescriptive Authority? ☐ Yes ☐ No
Gender: ☐ Male ☐ Female

Individual NPI: _____
Taxonomy: _____
SSN: _____
Date of Birth: _____
Individual Medicare ID: _____
Individual Medicaid ID: _____
Medicaid Issue State: _____
Medicaid Issue Date: _____

Primary Practice Location (cannot contain a PO Box)**:**

Primary Practice Address	City	State	Zip	Site Conditions	Availability
				☐ Evening Apps ☐ Weekend Appts ☐ Public Trans Access ☐ Wheelchair Access	☐ Inpatient or In-Home Only ☐ Accepting New Patients
Phone	**Secure Fax**	☐ **No Secure Fax**			

Additional Practice Location(s) (cannot contain a PO Box):

	Add	Delete	Practice Address	City	State	Zip	Site Conditions	Availability
1	☐	☐					☐ Evening Apps ☐ Weekend Appts ☐ Public Trans Access ☐ Wheelchair Access	☐ Inpatient or In-Home Only ☐ Accepting New Patients
			Phone	**Secure Fax**	☐ **No Secure Fax**			
2	☐	☐					☐ Evening Apps ☐ Weekend Appts ☐ Public Trans Access ☐ Wheelchair Access	☐ Inpatient or In-Home Only ☐ Accepting New Patients
			Phone	**Secure Fax**	☐ **No Secure Fax**			
3	☐	☐					☐ Evening Apps ☐ Weekend Appts ☐ Public Trans Access ☐ Wheelchair Access	☐ Inpatient or In-Home Only ☐ Accepting New Patients
			Phone	**Secure Fax**	☐ **No Secure Fax**			