A1 BEHAVIORAL HEALTH SERVICES
Substance Use Recovery and Education (S.U.R.E)

Provider Information Form

Fax to: (305) 935-1123

Today's date __ /__ /___ Name _____ Phone ____ - ____ - ____

Please complete ALL sections of this form.

TYPE OF INFORMATION BEING PROVIDED TO NETWORK HEALTH

☐ New individual provider ☐ Current individual provider

☐ New hospital or facility ☐ Current hospital or facility

TYPE OF INFORMATION BEING CHANGED/ADDED

☐ New provider profile ☐ Change existing name ☐ Add information to existing profile

☐ New provider profile for existing group ☐ Change existing practice address ☐ Add practice address

☐ Change existing billing address ☐ Add billing address (attach W-9)

☐ Change group affiliation ☐ Add group affiliation

Effective date for change/addition ___ /___ /___

SECTION A: PROVIDER AND PRACTICE INFORMATION

Provider information

Title _____ Last name _____ First name _____ M.I. ____ Sex ☐ M ☐ F

DOB ___ /___ /___ SSN _____ DEA # _____ MA lic # _____ NPI # _____

Provider e-mail _____ Race and/or ethnicity _____

Board certified ☐ Y ☐ N

For behavioral health providers only CANS certified ☐ Y ☐ N

Practice information

Primary specialty _____ Secondary specialty _____

☐ Other _____

Hospital affiliations _____

IPA/PHO affiliations _____

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SECTION B: PRACTICE LOCATION

Primary practice location

Practice name _____

Address _____

City _____ State _____ ZIP _____

Phone _____ - _____ - _____ Fax _____ - _____ - _____ Practice e-mail _____

Contact person _____ Title _____

Office hours Sun _____ Mon _____ Tue _____ Wed _____ Thu _____ Fri _____ Sat _____

Are you practicing as a PCP at this location? ☐ Y ☐ N *If yes, please check one box below.*

☐ Accepting new patients ☐ Seeing current patients only

Handicap accessibility ☐ Y ☐ N Age groups seen ☐ 0-18 ☐ 18-65 ☐ 65+ ☐ Other age group _____

Is this location public transportation accessible? ☐ Y ☐ N

Languages

☐ Spoken *Please specify.* _____

☐ Provided by interpreters *Please specify.* _____

Additional practice locations

Practice name _____

Address _____

City _____ State _____ ZIP _____

Phone _____ - _____ - _____ Fax _____ - _____ - _____ Practice e-mail _____

Contact person _____ Title _____

Office hours Sun _____ Mon _____ Tue _____ Wed _____ Thu _____ Fri _____ Sat _____

Are you practicing as a PCP at this location? ☐ Y ☐ N *If yes, please check one box below.*

☐ Accepting new patients ☐ Seeing current patients only

Handicap accessibility ☐ Y ☐ N Age groups seen ☐ 0-18 ☐ 18-65 ☐ 65+ ☐ Other age group _____

Is this location public transportation accessible? ☐ Y ☐ N

Languages

☐ Spoken *Please specify.* _____

☐ Provided by interpreters *Please specify.* _____

Please separately attach all of the above information for any additional practice locations.

SECTION C: COVERING PROVIDER INFORMATION (FOR PCPs ONLY)

Title _____ Last name _____ First name _____ M.I. _____ Sex ☐ M ☐ F

NPI # _____ Tax ID # _____

Please separately attach all of the above information for any additional covering providers.

SECTION D: BILLING INFORMATION*

**Please submit a W-9 for each new billing address.*

Tax ID # _____

For this Tax ID #, which claim form(s) will you use? *Please check one.*

☐ UB04 ☐ CMS 1500 ☐ Both

Name on check _____ is (*Please check one.*) ☐ Individual name ☐ Group name

Address _____

City _____ State _____ ZIP _____

☐ Send 1099 to this address. ☐ Send payments to this address. ☐ This is an EDI address. ☐ This is a new billing address.

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FOR NETWORK USE ONLY

Instructions:

- ☐ Set up new provider profile, effective ___ /___ /____ ☐ In network ☐ Out of network
- ☐ Change existing provider profile with above information, effective___ /___ /____
- ☐ Add information to existing provider profile with above information, effective ___ /___ /____
- ☐ Link provider to vendor/facility # _____ Fee code _____ effective ___ /___ /____ ☐ In network ☐ Out of network
- ☐ Link provider TIN # _____ to IPA/PHO panel # _____ effective ___ /___ /____
- ☐ Remove provider IPA affiliation from V/F # _____ effective ___ /___ /____ (provider still participating in plan)

For PCPs only

- ☐ Link provider to PCP group _____ effective ___ /___ /____
  IPA/PHO panel # _____
- ☐ Create new PCP group effective ___ /___ /____ IPA/PHO panel # _____
  PCP group name _____
  Address _____
  City _____ State _____ ZIP _____

Updated___/___/___ Completed by _____

SPECIAL INSTRUCTIONS: