COLORADO COMMUNITY HEALTH ALLIANCE

# Behavioral Health Practice Profile Update Form

Use the form below to submit updated behavioral health practice profile information to the Colorado Community Health Alliance (CCHA) Provider Relations department. Please submit the completed form by to your designated Provider Relations Representative or email CCHA@anthem.com. To locate your Provider Relations Representative, go to CCHAcares.com/providertools > *Behavioral Health Providers > Manuals and Resources > Behavioral Health Provider Contact List*.

**Directions**

1. Sections 1 and 2 must be completed for all submissions.
2. In sections 3 through 7, only complete the sections where your information has changed.
3. Section 5: Any change or update to the billing/remit information MUST include a current *W-9* form reflecting the same information noted in section 5.
4. Sign and date the form before submitting.

| **1. Provider information (Required)** | |
|---|---|
| Provider name: | |
| Provider group name (if applicable): | |
| Gender: ☐ Female ☐ Male | |
| Specialty: | |
| License #: | License # effective date: |
| Medicaid ID#: | Medicaid ID # effective date: |
| NPI: | TIN: |

| **2. What type of information are you updating? (Required)** | |
|---|---|
| **Please check all that apply.** | ☐ New or additional office location |
| ☐ Term provider: Effective date: | ☐ Remove an office location/remit address |
| Reason: _____ | ☐ _____ |
| ☐ Practice details | ☐ Other: _____ |
| ☐ Behavioral health provider details | Please complete the appropriate sections below based on the boxes checked. |
| ☐ Billing information (W-9 form required) | |

| **3. Practice details** | | | |
|---|---|---|---|
| Office hours | | | Age range of patients served: |
| Monday | _____ a.m. | _____ p.m. | ☐ Pediatrics ☐ Geriatric |
| Tuesday | _____ a.m. | _____ p.m. | ☐ All ages ☐ Other: _____ |
| Wednesday | _____ a.m. | _____ p.m. | |
| Thursday | _____ a.m. | _____ p.m. | Languages spoken: |
| Friday | _____ a.m. | _____ p.m. | |
| Saturday | _____ a.m. | _____ p.m. | |
| Sunday | _____ a.m. | _____ p.m. | Wheelchair/*ADA* accessible? ☐ Yes ☐ No |

| **4. Behavioral health (BH) provider details** |
|---|
| BH providers are required to have coverage 24/7. Please mark your coverage type below. |
| ☐ Answering service ☐ Beeper or pager ☐ Answering machine |
| ☐ Other phone number: _____ |
| Are you accepting new patients? ☐ Yes ☐ No |

**5. Billing information**

*Please attach a copy of the current *W-9* form for **all** billing information changes.

Effective date of change:

Billing address (City, State, ZIP):

Billing contact phone number:

Billing contact fax number:

Billing contact person:

Billing contact Email address:

**6. New or additional office location**

☐ New office location ☐ Additional office location

Will this **new** or **additional** location be the primary location? ☐Yes ☐ No

Office location name:

Effective date:

Office location address (City, State, ZIP):

Office manager:

Phone number:

Fax number:

Email address:

Accepting new patients? ☐ Yes ☐ No

| Office hours | | | Age range of patients served: |
|---|---|---|---|
| Monday | _____ a.m. | _____ p.m. | ☐ Pediatrics ☐ Geriatric |
| Tuesday | _____ a.m. | _____ p.m. | ☐ All ages ☐ Other: _____ |
| Wednesday | _____ a.m. | _____ p.m. | |
| Thursday | _____ a.m. | _____ p.m. | Languages spoken: |
| Friday | _____ a.m. | _____ p.m. | |
| Saturday | _____ a.m. | _____ p.m. | |
| Sunday | _____ a.m. | _____ p.m. | Wheelchair/*ADA* accessible? ☐ Yes ☐ No |

**7. Remove an office location / remit address**

Do you want to remove an office location? ☐ Yes ☐ No

Do you want to remove a remit address? ☐ Yes ☐ No

Office location address:

**Remit Address:**

| |
|---|
| **To add or remove additional office locations, attach a separate sheet.** |
| |
| **Signature:** |
| **Printed name:** |
| **Contact phone number:** |
| **Contact fax number:** |
| **Contact Email address:** |