Mercy Managed Behavioral Health
In-Network Provider Change Form

***When submitting this form please include Current Insurance, and W9** for NP's (Collaborative Agreement and/or Full-Practice Authority Documentation)*

Email this form to: mmbhproviderupdates@mercy.net

This Form is formatted for PDF; Numbers are formatted for exact numbers and charters- enter only numbers no special characters or spaces

Provider Change Information

Date Submitted: _____

Requester Name: _____ Requester E-mail: _____

Effective Date for Change: _____ Practice Name: _____

Provider Last Name: _____ First Name: _____ Middle Initial: ____

SSN: _____ DOB: _____ Provider NPI: _____ Group NPI: _____ TIN: _____

License Type: _____ *(e.g. MD, PhD, LCSW, LPC, etc)* State: _____

License Number: _____ Exp. Date: _____

Medicare Number: _____ Medicaid Number: _____

BNDD #: _____ Exp. Date: _____ DEA Number: _____ Exp. Date: _____

Mailing Address Change

Street Address: _____ Suite: _____

City: _____ State: ____ Zip Code: _____

Phone #: _____ Fax #: _____

Billing Address Change

Street Address: _____ Suite: _____

City: _____ State: _____ Zip Code: _____

Phone #: _____ Fax #: _____

Service Address Change

PRIMARY Practice Publish: ☐ Yes ☐ No

Address: Is Address: Business ☐ Yes ☐ No Home - if checked answer:

Separate Entrance: ☐ Yes ☐ No Meets HIPPA Requirements: ☐ Yes ☐ No

Street Address: _____ Suite: _____

City: _____ State: _____ Zip Code: _____ County: _____

Phone #: _____ Fax #: _____

- Which service types do you currently offer? **(select all that apply)**:
  - Telephonic Therapy **(telephone/no video)** ☐ Yes ☐ No
  - Telehealth/Telemedicine (telephone **with HIPAA compliant video**) ☐ Yes ☐ No
  - Face-to-Face (services **performed in person in an office setting**) ☐ Yes ☐ No

SECONDARY Practice Address Publish: ☐ Yes ☐ No Is Address: ☐ Business: ☐ Home

Home - if checked answer – Separate Entrance ☐ Yes ☐ No Meets HIPPA Requirements ☐ Yes ☐ No

Street Address: _____ Suite: _____

City: _____ State: _____ Zip Code: _____ County: _____

Phone #: _____ Fax #: _____

- Which service types do you currently offer? **(select all that apply)**:
  - Telephonic Therapy **(telephone/no video)** ☐ Yes ☐ No
  - Telehealth/Telemedicine (telephone **with HIPAA compliant video**) ☐ Yes ☐ No
  - Face-to-Face (services **performed in person in an office setting**) ☐ Yes ☐ No

Either Specify your preferred age range of clients or check all age groups that apply:

☐ Child Ages 0-5 ☐ Child Ages 6-11 ☐ Adolescent 12-17 ☐ Adult Ages 18-61 ☐ Geriatric 62+

If your preferred age ranges are different than above, please specify:

From among the specialties listed below, **RANK the top five (5)** in terms of your interests and expertise. This will help match patient needs and provider specialties and interests. *Rank 1 - 5 "1" indicates the greatest level, "5" = lowest level of interest and expertise* from among your five choices.

☐ ADHD	☐ Grief	☐ Borderline Personality Disorder
☐ AIDS/HIV+	☐ Groups – Adult	☐ Physical Disabilities
☐ Anxiety	☐ Groups - Men's	☐ Post-Partum
☐ Autism	☐ Groups - Women's	☐ Psychosis
☐ Biofeedback	☐ Groups - Recovery	☐ Rehabilitation Counseling
☐ Christian Counseling	☐ Groups - Child/Teen	☐ Serious Mental Illness
☐ Chronic Illness	☐ Home Visits - List Counties *in other*	☐ Sexual Abuse Female
☐ Cognitive TX	☐ Stress/Harassment	☐ Sexual Abuse Male
☐ Conduct DO	☐ Marital Therapy	☐ Sexual Identity
☐ Cultural Diversity	☐ Men's Issues	☐ Sexual Perpetrator Adult
☐ Depression	☐ Intellectual Disability	☐ Sexual Perpetrator Child
☐ Dual Diagnosis	☐ Neuropsych	☐ Substance Abuse
☐ Eating Disorders	☐ Obsessive Compulsive Disorder	☐ Suicide
☐ Gay/Lesbian Issues	☐ Pain Management	☐ Women's Issues
☐ Geriatric	☐ Personality Disorder	

☐ Other _____

For questions, please call Lawayna Lloyd (314) 729-4453 or Donna Schmitz at (314)729-4475 or Fax this form and any supporting documents to (314) 729-4636 – Attn: Provider Relations Teams-Provider Panel Updates

NOTES

Provider Notes:

For questions, please call Lawayna Lloyd (314) 729-4453 or Donna Schmitz at 314-729-4475 or* Fax to 314-729-4636 – *Attn: Provider Relations Team