



CONTRACT MAINTENANCE REQUEST FORM
PROVIDER INFORMATION

CONTRACT NAME: _____
TAX ID #: _____ DATE OF SUBMISSION: _____

Provider Best Contact Information

Name: _____ Contact E-mail: _____

Maintenance Request (Check all that apply):

- ADDRESS (Adding/termining a location or relocation)
- W9 CHANGE (remittance advice address change only)
- PROVIDER CHANGE (Adding or termining a provider)
- PHONE, FAX OR OFFICE HOURS

Maintenance Request Applies to the following:

Contract *This will apply the change to all providers listed on the contract

Individual Provider Provider Name: _____

Contract Type Behavioral Health Ancillary Specialist Urgent Care

PLEASE SEE THE BELOW CHECKLISTS AND INCLUDE REQUIRED DOCUMENTATION FOR EACH APPLICABLE MAINTENANCE REQUEST. PLEASE NOTE THAT FOR PCP/OBGYN (MD, DO, Extenders relating to PCP or OB/GYN contracts) REQUESTS, YOU SHOULD CONTACT YOUR PROVIDER SERVICES REPRESENTATIVE AT 909-890-2054.

Ancillary Contract Requests

- Adding Location/Relocation
 - i. Medi-Cal /Medicare participation letters
 - ii. Copy of State/Business license
 - iii. Copy of liability coverage
- Terminating Location
 - i. No documentation needed other than address information
- W9 Change
 - i. Attach new W9 (signed & dated)
- Phone, Fax, Hours
 - i. Please note change to the right

(APPLIES TO DME, HOME HEALTH, HOSPICE, SNF, ASC, FACILITIES)

Location (s) to be added:

Location (s) to be termed:

New Phone: _____

New Fax: _____

New Hours: _____

**Behavioral Health,
Specialists & Urgent Care-**
no required documentation
for these changes other
than noting the new
information on form.

Location (s) to be added and/or relocating to address:

Location (s) to be termed:

New Phone: _____

New Fax: _____

New Hours: _____

Provider(s) to be TERMED:	_____	Effective Date:	_____
	_____	Effective Date:	_____
Provider(s) to be ADDED:	_____	Effective Date:	_____
	_____	Effective Date:	_____

***ALL PROVIDERS- Please attach a credentialing application for any provider (MD, DO, NP, PA, LCSW, LMFT, Psychologists, Psychiatrists) not already credentialed with IEHP.**

****QASP Providers (BCBA's)- Please include Name, Cert #, Type (BCBA, RBT, Paraprofessional, etc), NPI, SSN & DOB for providers being added to contract. We do not require a credentialing application.**

By signing below, I authorize IEHP to make said changes as noted on maintenance form:

Name/Title: _____

Signature: _____ Date: _____

Please email this form to contractupdates@iehp.org upon completion.