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/terming a location or relocation)
- ☐ W9 CHANGE (remittance advice address change only)
- ☐ PROVIDER CHANGE (Adding or terming a provider)
- ☐ PHONE, FAX OR OFFICE HOURS **(fax number must be secure)

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
- Terming 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: (must be secure) _____

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: (must be secure) _____

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, Paraprofessi nal, etc), NPI, SSN & DOB for providers being added to contract. We do not require a credentialing applicati on.

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

Name/Title: _____

Signature: _____ Date: _____

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