# OPTUM SAN DIEGO PUBLIC SECTOR
# PROVIDER UPDATE FORM

**Dear Provider:**

**The purpose of this form is to request a change of name or address to your treatment location(s) as viewed on your provider profile and online provider directory, mailing address and/or billing address.**

**Please reference the following list of definitions as you complete this form.**

**TREATMENT LOCATIONS:**

**ACCEPTING NEW PATIENTS/CLIENTS:**
MEDI-CAL:

- **Accepting New Clients:**
  Access and Crisis Line can provide your contact information to callers who request a referral to a provider with your license type stating you are currently open to referrals for **outpatient** treatment.

- **Not Accepting New Clients:**
  Your contact information will NOT be provided to callers who are requesting a referral to a provider with your license type. You may still choose to accept clients through other sources, however, you will show as "Not Accepting New Clients" in the Provider Directory and Access and Crisis Line Provider Database.

**WAIT TIMES:**

| | |
|---|---|
| • **Urgent Appointments**<br>All services without prior approval | **Wait Time**<br>48 hours |
| • **Non-Urgent Appointment**<br>Specialist appointment (Physician)<br>Appointment with a mental health specialist (non-physician) | **Wait Time**<br>15 business days<br>10 business days |

**Please submit the completed Provider Update Form and supporting documents (if applicable) to:**

**Email: sdu_providerserviceshelp@optum.com**
**Fax: 877-309-4862**

**If you have any questions about completing this form, please contact Provider Services at 1-800-798-2254, option 7.**

# OPTUM SAN DIEGO PUBLIC SECTOR
# PROPLEASE

**PLEASE EMAIL OR FAX TO:**
**sdu_providerserviceshelp@optum.com or Fax # 877-309-486**

**PROVIDER NAME:**_____ **DATE:** _____

**ADD PRIVATE PRACTICE** ❒ **(Must submit W-9 Form)**

**ADD GROUP PRACTICE** ❒ **(Must submit W-9 Form)**

**EFFECTVE DATE:**_____

**Business Name:**

**Tax ID#:** _____

**NPI#:** _____

**NEW TAX I.D. NUMBER** ❒ **(Must submit W-9 Form)** **EFFECTVE DATE:**_____

❒ **W-9 Form must be signed and dated.**
❒ If your Taxpayer Identification Number (TIN) is your social security number, please provide a **copy of your social security card**.
❒ If your Taxpayer Identification Number (TIN) is an employer identification number (EIN), please provide a **copy of form SS-4** (IRS EIN assignment notification letter)

**ADD NEW TREATMENT LOCATION** ❒

**Business Name:**

**Address:**

**City/State/Zip:**

**Phone:**_____ **, Fax:** _____

**EMAIL (Client Use):**
**(Secure-HIPAA compliant)**

**EMAIL (Business Use):**

**ACCEPTING NEW PATIENTS/CLIENTS:**
MEDI-CAL:( including those from The San Diego Access and Crisis Line and the Provider Directory) [YES ❒ NO ❒]
TERM-CWS (If applicable) [YES ❒ NO ❒]

**WAIT TIMES:**
Urgent Appointments: _____ Hours
Non-Urgent Appointments: _____Business Days

**Does this office meet ADA* guidelines?** [YES ❒ NO ❒]
*Americans with Disabilities Act

**Is office accessible to public transportation?** [YES ❒ NO ❒]

**Home Office?** [YES ❒ NO ❒]

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**PLEASE EMAIL OR FAX TO:**
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**PROVIDER NAME:**_____ **DATE:** _____

| **ADD ADDITIONAL TREATMENT LOCATION ❒** |
|---|
| **Business Name:** |
| **Address:** |
| **City/State/Zip:** |
| **PHONE:**_____ **, FAX:** _____ |
| **EMAIL (Client Use):** **(Secure-HIPAA compliant)** |
| **EMAIL (Business Use):** |
| **ACCEPTING NEW PATIENTS/CLIENTS:** MEDI-CAL:( including those from The San Diego Access and Crisis Line and the Provider Directory) [YES ❒ NO ❒] TERM-CWS (If applicable) [YES ❒ NO ❒] |
| **WAIT TIMES:** Urgent Appointments: _____ Hours Non-Urgent Appointments: _____Business Days |
| **Does this office meet ADA* guidelines?** [YES ❒ NO ❒] *Americans with Disabilities Act |
| **Is office accessible to public transportation?** [YES ❒ NO ❒] |
| **Home Office?** [YES ❒ NO ❒] |

| **ADD NEW MAILING ADDRESS ❒** |
|---|
| **Business Name:** |
| **Address:** |
| **City/State/Zip:** |

| **ADD NEW BILLING ADDRESS ❒** **(Must submit W-9 Form)** **EFFECTVE DATE:**_____ |
|---|
| **Business Name:** |
| **Address:** |
| **City/State/Zip:** |
| **PHONE:**_____ **, CONTACT:** _____ |

# OPTUM SAN DIEGO PUBLIC SECTOR
# PROVIDER UPDATE FORM

**PLEASE EMAIL OR FAX TO:**
**sdu_providerserviceshelp@optum.com or Fax # 877-309-486**

**PROVIDER NAME:**_____ **DATE:** _____

**REMOVE GROUP PRACTICE ❒**

**REMOVE PRIVATE PRACTICE ❒**

**EFFECTVE DATE:**_____

**Business Name:**

**Treatment Location Address:**

**City/State/Zip:**

**PHONE:**_____ **, FAX:**_____ **, CONTACT:** _____

**GROUP Tax ID#:** _____

**GROUP NPI#:** _____

**DO YOU CURRENTLY HAVE OPEN AUTHORIZATIONS THAT NEED TO BE MOVED TO YOUR NEW PRACTICE: Y/N**

***If Yes, please provide a list of clients.**