SANDHILLS CENTER

Managing Mental Health, Intellectual/Developmental Disabilities and Substance Abuse Services
910-673-9111 (FAX) 910-673-6202 www.sandhillscenter.org Victoria Whitt, CEO

NOTICE OF CHANGE REQUEST FORM

Please include all of the information requested along with submission of supporting documentation.

Missing or Incomplete Information will result in your request not being processed.

Please indicate which type of provider you are and provide all requested information

Agency	Licensed Independent Practitioner (LIP)	Hospital
Name:		
Federal Tax ID:	Social Security Number:	
NPI #:		
Primary Address:		
Phone Number:		

Primary Contact Person for this change request

Contact Name:
Contact Title/Position:
Contact Address:
Contact Phone:
Contact Email:

Please fill out **only** the **section(s)** that apply to the change(s) that you are requesting.

Directions: Please submit pages 1, 2 and 10 (signature pages) of this form, along with the appropriate completed Section(s), as instructed on page 10.

Please check the appropriate box(es) for the requested change(s) and complete the corresponding sections

Change	Effective Date	Section
Name Change	Effective Date:	Complete Section A
Mailing Address Change	Effective Date:	Complete Section B
Billing Address Change	Effective Date:	Complete Section B
Service/Site Location Address Change	Effective Date:	Complete Section B
Phone # Only Add/Delete	Effective Date:	Complete Section B
Add an additional Site	Effective Date:	Complete Section C
Add an additional Service	Effective Date:	Complete Section D
Remove a Site Location	Effective Date:	Complete Section E
Remove a Service	Effective Date:	Complete Section F
Update After Hours Coverage Information	Effective Date:	Complete Section G
Update Hours of Operation	Effective Date:	Complete Section H
Update Professional License/Certification	Effective Date:	Complete Section I
Update Certificate of Coverage for Automobile Liability Insurance	Effective Date:	Complete Section J
Update Certificate of Coverage for Comprehensive General Liability	Effective Date:	Complete Section J
Update Certificate of Coverage for Professional Liability Insurance	Effective Date:	Complete Section J
Update Certificate of Coverage for Workers Compensation and Occupational Disease Insurance	Effective Date:	Complete Section J
Remove a Licensed Independent Practitioner	Effective Date:	Complete Section K
Add a Previously Credentialed Licensed Independent Practitioner	Effective Date:	Complete Section L
Primary Contact Person Change	Effective Date:	Complete Section M
Add / Change / Remove NPI	Effective Date:	Complete Section N
Change of Business Entity Type	Effective Date:	Complete Section O
Change of Ownership	Effective Date:	Complete Section P
Change of "Other" – (i.e. change in Medical Director)	Effective Date:	Complete Section Q

Section A: Name Change – Complete and Submit with supporting documentation

Effective Date:	
CURRENT Name:	
NEW Name:	
Reason for Name Change:	Other:

You must submit supporting documentation with this form indicating name change (e.g., Updated Certification of Insurance, W9, Government issued ID or Marriage Certificate (if individual name), change of Name Documents), this list is not all inclusive.

Section B: Address/Phone Change

Effective Date:					
Type of Address:	Mailing	Billing	Phone/Fax Number only	Service Site	Corporate

Delete Address/Phone/Fax Information

Delete Address:			
Street	*City*	*State*	*Zip+4 (Required)*
Delete Phone Number:	Delete Fax Number:		

New Address/Phone/Fax Information

New Address:			
Street	*City*	*State*	*Zip+4 (Required)*
New Phone Number:	New Fax Number:		
Contact Person Name/Title:			
Email:			
Handicapped Accessible:	Yes	No	

Section C: Add Additional Site(s)

Effective Date:	Alpha Provider ID #:
Site Name:	
Site Physical Address:	
County:	
NPI #:	
Contact Person's Name:	
Contact's Email & Phone:	
Is this site an AFL? *(If yes, please complete the following information. Required)* Yes No	
Member's Name:	Member's ID#:
Expected Move In Date for Member:	
Name of Care Coordinator:	

Is this site staffed and equipped to serve: ***(please check "yes" or "no" for each item below)***		
Physically Handicap:	Yes	No
Blind/Visually Impaired:	Yes	No
Sexually Aggressive:	Yes	No
Foreign Language: (if "yes" specify language)	Yes	No
Deaf & Hearing Impaired:	Yes	No
Behaviorally Disruptive:	Yes	No

Hours of Operation:

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

If you are adding more than one site, please copy this page for each additional site.

SHC Network Operations Department will schedule an On-Site Review for each additional site/service, if applicable.

Section D: Add Additional Service(s)

Effective Date:		Type of Service: Medicaid IPRS		
Population(s) to be Served: I/DD MH SA				
Ages to be Served: Birth-3 years Child/Adolescent Adult Geriatric				
Consumer Capacity:				
List all services that you are requesting to provide. Services must be listed as defined by NC DHHS service definitions.				
Site(s) Name	Service(s) Code	Service Description	Require Licensure?	Require Accreditation?
			Yes	Yes
			No	No
			Yes	Yes
			No	No
			Yes	Yes
			No	No

If the site / service(s) you are adding require a license and/or accreditation, you must attach a copy of the valid license and/or accreditation.

Section E: Remove a Site Location *(Closure of site and all services provided at site; not an address change.)*

Planned Closing Date:	
Name of Site:	Site NPI #:
Address:	
Street *City*	*State* *Zip+4 (Required)*
Phone number for this site:	Fax number:
SHC Consumers to transition: Yes No	Outstanding Billing: Yes No
Contact person at this site:	
Contact E-mail:	
County in which this site is located: Anson Guilford Harnett Hoke Lee Montgomery Moore Randolph Richmond Other:	
List **all services** and **corresponding service codes** that are **being discontinued** ***(attach additional sheet if needed):***	
Service Code(s) to remove:	Service Description:

Are Licensed Practitioners at this site that need removed from the agency: Yes No *(if yes provide names and end dates in mm/dd/year format below, attaching additional pages if necessary)*		
License Practitioner Name	Licensed Practitioner NPI	End Date

Section F: Remove a Service

Effective Date:	Type of Service(s): Medicaid IPRS
Population(s) served: I/DD MH SA	
Ages served: Birth – 3 years Child/Adolescent Adult Geriatric	

Service(s) to Remove (attach additional pages as necessary):

Site(s) where service(s) will be removed	Service code(s) to remove	Service Description

Section G: Update After Hours Coverage Information

Effective Date:			
Site Name:			
Address:			
Street	*City*	*State*	*Zip+4 (Required)*

County:

Anson	Guilford	Harnett	Hoke	Lee
Montgomery	Moore	Randolph	Richmond	Other:

Previous after hours coverage:	**New after hours coverage:**
Name:	Name:
Address:	Address:
Phone:	Phone:
Fax:	Fax:
Name:	Name:
Address:	Address:
Phone:	Phone:
Fax:	Fax:
Name:	Name:
Address:	Address:
Phone:	Phone:
Fax:	Fax:
Name:	Name:
Address:	Address:
Phone:	Phone:
Fax:	Fax:

Section H: Update Hours of Operation

Effective Date:			
Site Name:			
Address:			
Street	*City*	*State*	*Zip+4 (Required)*

County:

Anson	Guilford	Harnett	Hoke	Lee
Montgomery	Moore	Randolph	Richmond	Other:

Site Contact:	Phone:
Email:	

Old Hours of Operation at this Site:

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

New Hours of Operation at this Site:

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

Section I: Update / Change Professional License/Certification

Type of License/Certification Add/Update/Change:		
"Add" - for SHC to add another license/certification to your profile "Update" – i.e. Renewal of licensure/certification "Change" – i.e. Name Change		
Effective Date:		
Reason for Update/Change:		
Clinician Name:		
Practice Site(s):		
Address:		
Street	*City*	*State* *Zip+4 (Required)*
County: Anson Guilford Harnett Hoke Lee Montgomery Moore Randolph Richmond Other:		
License/Certification #:	Practitioner NPI:	
License Type:	Renewal Date:	Expiration Date:
Certification Type:	Effective Date:	Expiration Date:

Supporting documentation must be submitted with this form.
Please attach a copy of the license/certification renewal letter from your Board.

Section J: Update Certificate of Insurance Coverage

***Attach additional pages if needed. ***

Effective Date:			
Type of Insurance updated/renewed:			
Update Certificate of Coverage for Automobile Liability Insurance Update Certificate of Coverage for Comprehensive General Liability Update Certificate of Coverage for Professional Liability Insurance Update Certificate of Coverage for Workers Compensation and Occupational Disease Insurance			
Coverage of:	Agency	Individual	Hospital
Name of Agency/Individual/Hospital:			
Address/Site Location where insurance is in effect:			
Street	*City*	*State*	*Zip+4 (Required)*
Expiration Date:			

******Copy of Certificate of Insurance (COI) must be submitted with this form. (Submission of a Letter of Intent is NOT sufficient, it must be a Certificate of Insurance (COI) ******

Section K: Remove a Licensed Independent Practitioner (LIP)

Effective Date:	NPI Number:
LIP Name:	
Reason for Leaving:	

Section L: To Add a Previously Credentialed Licensed Independent Practitioner (LIP)

LIP Name:	NPI Number:

Originally Credentialed With

Name of Agency or Group Originally Credentialed With:	
Still Employed By: Yes No	Effective Date (if No):

New Agency to be Linked With

Date of Hire:		
Name of Agency:		
Primary Office Address:		
Street	*City*	*State* *Zip+4* *(Required)*
Phone #:	Fax #:	
Secondary Office Address *(if applicable)*:		
Street	*City*	*State* *Zip+4* *(Required)*
Phone #:	Fax #:	
Federal Tax ID Number:		
Type of Practitioner: Fully Licensed / Provisionally Licensed	License #:	

Priority Population:

MH – Adult	SA – Adult	I/DD - Adult
MH – Child	SA – Child	I/DD - Child

County:

Anson	Guilford	Harnett	Hoke	Lee
Montgomery	Moore	Randolph	Richmond	Other:

Office Hours of Operation

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

Arrangements For

24/7 Day Coverage ***(please describe)***:

Emergency Coverage ***(please describe)***:

Practitioner Printed Name

Practitioner Signature Date

Phone #:	Email:

******Supporting documentation must be submitted with this form. Please attach a copy of your License, Supervision Contract/Email (if Provisional) and Certificate of Malpractice Insurance for the New Agency/Group******

Section M: Primary Contact Person Change

Effective Date:	
Delete this contact person:	
Add this contact person:	
Title:	
Email:	
Phone:	Fax:
County: Anson Guilford Harnett Hoke Lee Montgomery Moore Randolph Richmond Other:	
This contact person is confirmed for the following:	
Site Names	Addresses
This Contact is the primary contact for the following issues: Billing Contracts Appointments Clinical General Administrative Human Resources Other Other Other	

*Section N: Add/Change/Remove to National Provider Identifier (NPI) Number

Effective Date:			
Reason for Change:			
Type of Change:	Add National Provider Identifier	Change NPI (NPI correction)	Remove NPI
This NPI Number is for:	Agency Site Location	Individual Service	Group
NPI Number:			
Name of Individual/Group or Agency:			
Name of Site Location:			
Address:			
Street	*City*	*State*	*Zip+4 (Required)*
**** Please submit a copy of the NPPES documentation.***			

*Section O: Change of Business Entity Type

Effective Date:			
Old Entity Type:	C Corporation General Partner	S Corporation Professional Limited Liability Corporation	Sole Proprietorship Limited Liability Partnership
New Entity Type:	C Corporation General Partner	S Corporation Professional Limited Liability Corporation	Sole Proprietorship Limited Liability Partnership

**** Please contact the Provider Helpdesk at (855) 777-4652 or via email at providerhelpdesk@sandhillscenter.org to discuss business entity changes as this may require a revision to your current contract with Sandhills Center.***

Section P: Change in Ownership

Agency Name:		
Current Owner(s) with 5% or more ownership interest:		
New Owner(s) with 5% or more ownership interest:		
Mailing Address:		County:
New Owner(s) with 5% or greater ownership interest	Social Security #(s)	Date(s) of Birth
Please supply an SBI Verification form for all owners with 5% or greater, As well as additional documentation as applicable.		
SBI Verification Form		

Section Q: Change "Other" (i.e. change in Medical Director)

If the list on page 2 does not reflect the change request you need to make, please complete the text box below with your request.

DOCUMENTS SUBMITTED AND SIGNATURE PAGE

Please check or list documents submitted with this change request:

License Renewal Verification
SBI Form
NPPES Letter
Accreditation Letter
Government Issued ID
Supervision Contract
Corporate Verification
W-9
Initial License Issue
Name Change Documents: Type
Certificate of Coverage for Automobile Liability
Certificate of Coverage for Comprehensive General Liability
Certificate of Coverage for Professional Liability
Certificate of Coverage for Workers Compensation & Occupational Disease Insurance
Certificate of Coverage for Malpractice Insurance ***(Add an Already Credentialed Licensed Independent Practitioner)***
Other Certificate of Insurance: Type
Other

YOUR COMPLETED CHANGE REQUEST MUST INCLUDE THE FOLLOWING:

- **Page 1 and 2 – Demographic Page and Change Request Checklist**
- **Completed Section Corresponding to Change Request**
- **Page 10 – Documents Checklist and Signature Page**
- **All Supporting Documentation**

Submitted By (Print Name)

Signature *Date*

Phone #: *Email:*

PLEASE SUBMIT BY WAY OF:

You may email or fax the forms to your assigned Credentialing Specialist
Or
Mail To: Sandhills Center
Attention: Credentialing Specialist
(If you know your credentialing specialist please include their name)
P.O. Box 9
West End, NC 27376
Fax # (910) 673-7013