



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

Effective July 1st, 2017 All Providers are responsible for updating and maintaining NC Tracks to ensure proper payment from Sandhills Center.

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 12 (signature pages) of this form, along with the appropriate completed Section(s), as instructed on page 12.

P.O. Box 9, West End, NC 27376
24-Hour Access to Care Line: 800-256-2452
TTY: 1-866-518-6778 or 711
Serving Anson, Guilford, Harnett, Hoke, Lee, Montgomery,
Moore, Randolph, & Richmond Counties



Is this site an AFL? <i>(If yes, please complete the following information. Required)</i>	Yes	No
Is the Member a minor?	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

Section C: Add Additional Site(s)

Effective Date:	Alpha Provider ID #:
Site Name:	
Site Physical Address:	
County:	
NPI #:	
Taxonomy number(s):	
Contact Person's Name:	
Contact's Email & Phone:	
Is this site an AFL? <i>(If yes, please complete the following information. Required)</i>	Yes No
Is the Member a minor?	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
Deaf & Hearing Impaired:	Yes No
Behaviorally Disruptive:	Yes No
Foreign Language: (if "yes" specify language)	Yes No
Plan to accommodate those members with physical disabilities	

Hours of Operation:

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

Is this facility/site licensed by: (if yes, attach copy of the license)?			
DHSR:	Yes	No	License #: State:
DSS:	Yes	No	License #: State:
Other:	Yes	No	Type:
Information about the Facility/Site Director/ Supervisor: (if necessary, add additional page(s))			
Facility/Site Director's Name:			
Facility/Site Director's Credentials:			
Facility/Site Director's Education:			
Facility/Site Director's Phone #:			
Facility/Site Director's Email:			

Cultural, Gender, and Linguistic Data Form

By providing the information below, you will be assisting Sandhills Center with member/provider matching as well as providing information necessary for analyzing the Network and its ability to meet our Members cultural, racial, ethnic and linguistic needs. This information will reside within Sandhills Center Provider Directory and the online Provider Search.

Population(s) that you serve (please check (√) all that apply):		
Early Childhood (0-4)	Child & Adolescent (5-21)	Adult (22+)
Geriatrics (55+)	Female	Gay & Lesbian
HIV/Aids	Hearing Impaired*	Male
Gender Identity Issues	Sexually Reactive/Aggressive Youth	Visually Impaired**
* Deaf and Hard of hearing – hearing impaired equipment/services are offered by provider.		
** Visually Impaired – facility is set up with Braille signage and brochures/forms/documents.		
Culturally diverse populations the Agency feels competent to treat (please check (√) all that apply):		
White	Black or African American	American Indian and Alaska Native
Asian, Pacific Islander	Hispanic or Latino	Other:
Language(s) the Agency are able to communicate in fluently (please check (√) all that apply):		
The agency must explain or attach their organizational plan for sustaining their ability for the interpretation services checked below – direct language services through hiring staff or other translation entities.		
NOTE: Do not consider licensed individual practitioners as part of your agency languages. Sandhills Center has already collected the clinicians' languages spoken that will be credited toward your Agency.		
American Sign Language	English	French
German	Hmong	Portuguese
Russian	Spanish	Telugu
Other:		
Yes	No	- Completed Cultural Competency Training.

Practice Preference Data		
Focus of Treatments the Agency Provides (please check (√) all that apply):		
Mental Health		Intellectual / Developmental Disabilities
Chemical Dependency/Substance Abuse		Eating Disorder
Co-Occurring/Dual DX-Mental Illness, Mental Health, Substance Abuse		
Agency Expertise/Certified Specialties (please check (√) all that apply):		
Psychiatry	Self-Direction	Psychological Testing
Crisis Services	Marriage & Family Counseling	Therapeutic Foster Care
Outpatient Therapy	MST (Multi Systemic Therapy)	Intensive In-Home Therapy
Residential Services	Inpatient Services	Trauma Focused Services
Community Based Services	Detoxification Services	Faith Based Services
Co-Location with/Primary Care Physician		Telemedicine
<i>Thank you for taking the time to submit this form. If this form is not completed and returned, your agency will not appear within the Sandhills Center on line Provider Search.</i>		

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 requires 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:					
<i>Street</i>	<i>City</i>	<i>State</i>	<i>Zip+4 (Required)</i>		
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:				
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:	
<hr/>			
Name:		Name:	
Address:		Address:	
Phone:		Phone:	
Fax:		Fax:	
<hr/>			
Name:		Name:	
Address:		Address:	
Phone:		Phone:	
Fax:		Fax:	
<hr/>			
Name:		Name:	
Address:		Address:	
Phone:		Phone:	
Fax:		Fax:	

Section H: Update Hours of Operation

Effective Date:					
Site Name:					
Address:					
<i>Street</i>	<i>City</i>	<i>State</i>	<i>Zip+4 (Required)</i>		
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:				
<i>Street</i>		<i>City</i>	<i>State</i>	<i>Zip+4 (Required)</i>
County:				
Anson	Guilford	Harnett	Hoke	Lee
Montgomery	Moore	Randolph	Richmond	Other:
License/Certification #:		Practitioner NPI:		
Practitioner Taxonomy number(s):				
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:			
<i>Street</i>		<i>City</i>	<i>State</i> <i>Zip+4 (Required)</i>
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:
Taxonomy number(s):	

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:				
<i>Street</i>		<i>City</i>	<i>State</i>	<i>Zip+4 (Required)</i>
Phone #:		Fax #:		
Secondary Office Address <i>(if applicable)</i> :				
<i>Street</i>		<i>City</i>	<i>State</i>	<i>Zip+4 (Required)</i>
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
	Montgomery	Moore	Randolph	Lee 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
	Montgomery	Moore	Randolph	Lee 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 National Provider Identifier (NPI)/Taxonomy Number**

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

***Section O: Change of Business Entity Type**

Check appropriate box for federal tax classification of the person whose name is entered on line 1 of the W-9 form.		
Effective Date:		
Old Entity Type:		
Individual/Sole Proprietor or Single-member LLC	C Corporation	S Corporation
Partnership	Trust/Estate	LLC C S P
Other:		
New Entity Type:		
Individual/Sole Proprietor or Single-member LLC	C Corporation	S Corporation
Partnership	Trust/Estate	LLC C S P
Other:		
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.		
A W-9 request for Taxpayer ID number & certification is required. See the most recent W-9 form & instructions.		

***Section P: Change in Ownership**

Disclosure by Medicaid providers & fiscal agents: Information on ownership and control: 42 C.F.R. 455.104 (c) (1) (iv) Disclosures from providers or disclosing entities is due within 35 days after any change in ownership of the disclosing entity.

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.		
<u>SBI Verification Form</u>		
<i>W-9 request for Taxpayer ID number & certification is required.</i>		

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 (See IRS.gov website link for the most recent W9 form. https://www.irs.gov/forms-pubs/about-form-w9 .)
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 (<i>Add an Already Credentialed Licensed Independent Practitioner</i>)
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 12 – 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