



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

**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:		
Primary Address:		
Phone Number:		

Primary Contact Person for this change request
Contact Name:
Contact Title/Position:
Contact Address:
Contact Phone:
Contact Email:

Please complete only the section(s) that apply to the change(s) that you are requesting.

Directions: Please submit pages 1, 2 and 8 (signature pages) of this form, along with the appropriate completed Section(s), as instructed on page 8.

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



Please check the appropriate box(es) for the requested change(s) and complete the corresponding sections. The Selection & Retention Specialist will confirm your information in NC Tracks.		
Name Change (confirmed in NC Tracks)	Effective Date:	Complete Section A
Mailing Address Change (confirmed in NC Tracks)	Effective Date:	Complete Section B
Billing Address Change (confirmed in NC Tracks)	Effective Date:	Complete Section B
Service/Site Location Address Change (confirmed in NC Tracks)	Effective Date:	Complete Section B
Phone # Only Add/Delete (confirmed in NC Tracks)	Effective Date:	Complete Section B
Add an additional Site Unlicensed	Effective Date:	Complete Section C
Add an additional Service Unlicensed	Effective Date:	Complete Section D
Remove a Site Location from your contract	Effective Date:	Complete Section E
Remove a Service from your contract	Effective Date:	Complete Section F
Update After Hours Coverage Information	Effective Date:	Complete Section G
Update Hours of Operation	Effective Date:	Complete Section H
Remove a contracted Licensed Independent Practitioner	Effective Date:	Complete Section I
Primary Contact Person Change or Addition	Effective Date:	Complete Section J

Section A: Name Change (confirm in NC Tracks)	
Effective Date:	
CURRENT Name:	
NEW Name:	
Reason for Name Change:	

Sandhills Center will confirm that the above information is found in the Centralized Credentialing Provider Enrollment File (PEF).

Section B: Address/Phone Change (confirm in NC Tracks)	
Effective Date:	
Type of Address:	Mailing Billing Phone/Fax Number only Service Site Corporate
Delete Address/Phone/Fax Information	
Delete Address:	
<i>Street</i>	<i>City</i> <i>State</i> <i>Zip+4 (Required)</i>
Delete Phone Number:	Delete Fax Number:

[New Address/Phone/Fax Information](#)

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

For Current AFL providers only

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:	Member's Birth Date:	

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) Unlicensed						
Effective Date:			Alpha Provider ID #:			
Site Name:						
Site Physical Address:						
County:						
NPI #:						
Contact Person's Name:						
Contact's Email & Phone:						
For Current AFL Provider Only						
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:			Member's Birth Date:			
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

Cultural, Gender, and 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, and ethnic needs. This information will reside within Sandhills Center Provider Directory and the online Provider Search.

Population(s) that you serve (please check (v) 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**
<p>* Deaf and Hard of hearing – hearing impaired equipment/services are offered by provider.</p> <p>** Visually Impaired – facility is set up with Braille signage and brochures/forms/documents.</p>		
Culturally diverse populations the Agency feels competent to treat (please check (v) all that apply):		
White	Black or African American	American Indian and Alaska Native
Asian, Pacific Islander	Hispanic or Latino	Other:
Yes	No	Completed Cultural Competency Training.

Practice Preference Data		
Focus of Treatments the Agency Provides (please check (v) 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 (v) 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.](#)

[Sandhills Center Network Operations Department will schedule an On-Site Review for each additional site/service, if applicable.](#)

[Health & Safety reviews are conducted for All Unlicensed Sites](#)

Section D: Add Additional Service(s) Unlicensed				
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

Section E: Remove a Site Location from your contract. (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:	
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	Davidson	Guilford	Harnett	
Hoke	Lee	Montgomery	Moore	
Randolph	Richmond	Rockingham	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 there Licensed Practitioners at this site that need to be 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			End Date	

Section F: Remove a Service from your contract.				
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:				
<i>Street</i>		<i>City</i>		<i>State</i> <i>Zip+4 (Required)</i>
County:				
Anson	Davidson	Guilford	Harnett	
Hoke	Lee	Montgomery	Moore	
Randolph	Richmond	Rockingham	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 Operations

Effective Date:

Site Name:

Address:

<i>Street</i>	<i>City</i>	<i>State</i>	<i>Zip+4 (Required)</i>
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County:

Anson	Davidson	Guilford	Harnett
Hoke	Lee	Montgomery	Moore
Randolph	Richmond	Rockingham	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: Remove a contracted Licensed Independent Practitioner

Effective Date:

LIP Name:

Reason for Leaving:

Section J: Primary Contact Person Change

Effective Date:

[Delete](#) this contact person:

[Add](#) this contact person:

Title:

Email:

Phone: _____ Fax: _____

County:

Anson	Davidson	Guilford	Harnett
Hoke	Lee	Montgomery	Moore
Randolph	Richmond	Rockingham	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

Documents Submitted and Signature Page
Please list documents submitted with this change request:

YOUR COMPLETED CHANGE REQUEST MUST INCLUDE THE FOLLOWING:

- ➡ **Pages 1 and 2 – Demographic Page and Change Request Checklist**
- ➡ **Completed Section Corresponding to Change Request**
- ➡ **Page 8 – Documents and Signature Page**

Submitted By (Print Name)

Signature

Date

Phone #:

Email:

Email the completed form to your Selection and Retention Specialist. If you are unsure of your specialist, please contact the Provider Help Desk at providerhelpdesk@sandhillscenter.org or call (855) 777-4652.