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.

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

☐ 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 or Addition	Effective Date:	Complete Section M
☐ Add / Change / Remove NPI or Taxonomy	Effective Date:	Complete Section N
☐ Change of Business Entity Type* (must complete most recent W9)	Effective Date:	Complete Section O
☐ Change of Ownership* (must complete most recent W9)	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			

Is this site an AFL? *(If yes, please complete the following information. Required)*	◯ 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? *(If yes, please complete the following information. Required)*	◯ 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
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.

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:			
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 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	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:		
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:			
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:
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:			
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 National Provider Identifier (NPI)/Taxonomy Number

Effective Date:			
Reason for Change:			
Type of Change:	◯ Add National Provider Identifier	◯ Change NPI (NPI correction)	◯ Remove NPI
	◯ Add Taxonomy Number	◯ Remove Taxonomy Number	
This NPI Number is for:	◯ Agency	◯ Individual	◯ Group
	◯ Site Location	Service	
NPI Number:			
Taxonomy number(s):			
Name of Individual/Group or Agency:			
Name of Site Location:			
Address:			
Street	*City*	*State*	*Zip+4 (Required)*

**** 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.		
SBI Verification Form		
W-9 request for Taxpayer ID number & certification is required.		

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 ***(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 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