Agency Provider Add/Exit Form

This form and all content will be used solely for RMHS internal business requirements.

Please complete and submit this form to add or remove providers to the RMHS provider network; Email to: dcastle@rmhumanservices.org

Instructions: Please complete items 1-14 for adding providers; only 15-17 is needed for providers resigning or being terminated.

1. Provider Legal Name:______________________________DOB:_________________________________
2. Agency Name:____
3. Provider Title/Degree:___________________________________Start Date:______________________
4. Is this employee a W-2 employee with the agency listed above? ☐ **YES** ☐ NO
5. Medicaid Participation: **All providers must be a Medicaid approved provider prior to receiving RMHS referrals.**
   a. Has the provider been approved by Medicaid? ☐ YES, ID#___________________________
   b. Does the company bill under an agency Medicaid ID? ☐ YES, ID#______________________
6. **Provider Credentialing – If RMHS will be handling your billing for Denver Health, the provider will be required to go through the formal credentialing process. RMHS requires the following provider types to complete credentialing prior to receiving referrals for clients with DH: PT, OT, SLP, BCBA, RBT, LCSW, LSW, LP, LPC and PhD**. RMHS uses CAQH ProView for credentialing; if the provider has not completed a CAQH profile, please complete at https://proview.caqh.org/Login/Index?ReturnUrl=%2f. Is the providers CAQH up to date? ☐ YES
7. **Does the provider have an EI Provider Portal Account?** ☐ **YES** ☐ NO
8. Date of EICO Provider Training:___________________ Is the certificate in the EI portal? ☐ YES
9. State License #:__________________________________ Expiration Date:_______________________
10. Provider NPI:______________________________CAQH#:____
11. Board Certification (if applicable):______________________________________(ASHA, NBCOT, etc.)
    a. Certification #:____________________________ Expiration Date:________________________
12. Languages spoken:____
13. Contact Information:

    E-Mail Address:____

    Cell Phone:____________________________Office Phone:_________________________________

14. Telehealth Services:

    Are you requesting to use Telehealth as a service delivery modality? ☐ YES ☐ NO

15. Person Completing Form:____

    Title:____

Provider Exit Form

16. Providers Name:____

17. Agency Name:____

18. Exit Date:____

19. Reason for Exit:____