Early Intervention Program
Opt-In Provider Update Form

Please complete and submit this form to add or remove providers to the RMHS Early Intervention Provider Network; email to:juspratt@rmhumanservices.org. This form and all of its contents will be used solely for RMHS internal business requirements.

Please complete items 1-18 for new providers. Bottom section only is needed for terming providers.

1. **Provider Full Legal Name**:
2. **Agency Name**:
3. **Provider Title/Degree**:
4. **Start Date**:
5. **Medicaid Participation: All Providers must be an approved Medicaid Provider prior to receiving RMHS referrals**.

   Has this provider been approved by Medicaid? ☐ **YES** ID #

   If NO, has Provider's application been submitted to Medicaid? ☐ YES ☐ NO
6. **Provider Credentialing - RMHS requires the following provider types to complete a formal credentialing process prior to receiving referrals: PT, OT, SLP, BCBA, RBT, LCSW, LSW, LP, LPC and PhD.** RMHS utilizes CAQH ProView for credentialing. If provider has not completed a CAQH profile, please do so as soon as possible at **https://proview.caqh.org/Login/index?ReturnUrl=%2f**. RMHS Credentialing can provide instructions if needed; please email juspratt@rmhumanservices.org for assistance.
7. **CAQH #:**
8. **Provider NPI #:**
9. **DOB:**
10. **DORA License #:**
11. **Expiration Date:**
12. **SS #:**
13. **Board Certification if Applicable**:

    Certifying Board: (ASHA, NBCOT, etc.)

    Certification # Expiration Date:
14. **Languages fluently spoken other than English**:

15. **Contact Information:**

    Provider Preferred E-Mail Address:

    Phone #:

    Credentialing Manager Name & E-Mail Address:

16. **Are you requesting to provide <u>Telehealth Services</u> as a service delivery modality?**

☐ YES ☐ NO

☐ In addition to in-person services?

<u>OR</u>

☐ Do you wish to provide Telehealth Services only?

Note: Additional information is required; **please request Telehealth Provider Attestation.**

17. **Billing/Claims: Please note that RMHS does not direct bill Medicaid on behalf of Providers.** RMHS automatically bills Denver Health (a Medicaid plan) on behalf of all EI providers.

Do you/your organization agree to have RMHS bill Commercial Plans on your behalf?

☐ YES ☐ NO

Provider Exit Form – Please provide a 30 day notification of resignations/terminations.	
Provider's Name:	Exit Date:
Reason for Exit:	
Agency:	
Person Completing Form:	Date: