CalOptima Health User Guide

ADD, CHANGE AND TERMINATION (ACT) FORM

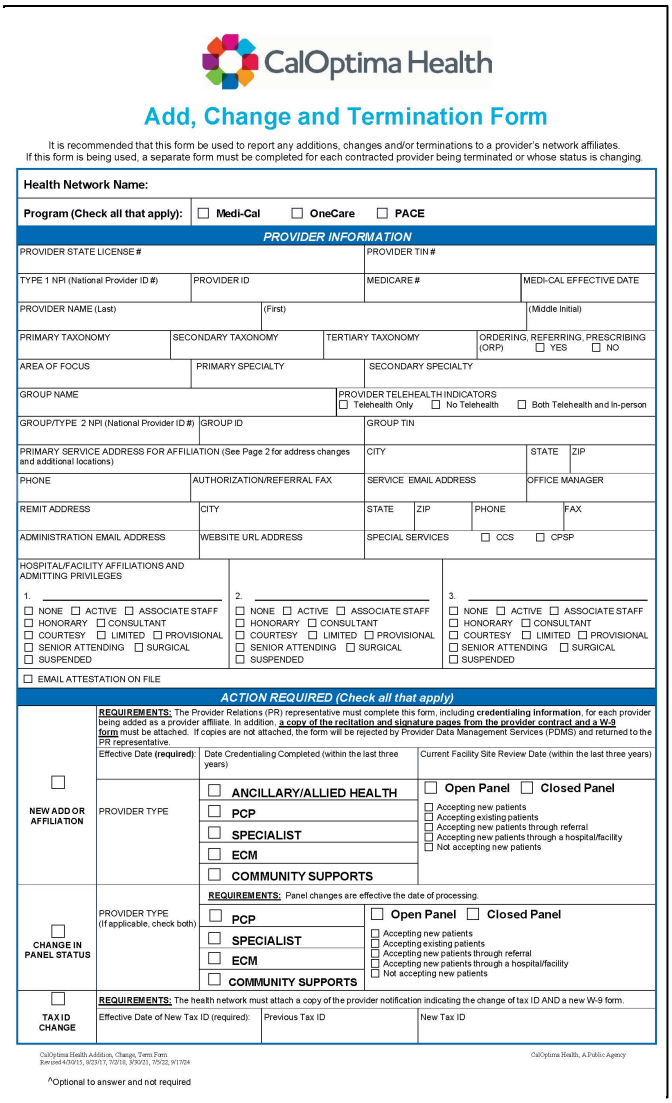
REQUIREMENTS

CalOptima Health requires its health networks (HN), subdelegates, providers and practitioners to promptly inform us of any changes to information regarding practitioner:

- **Demographics**
- **Credentialing**
- **Panel status —** including accepting new patients, accepting existing patients, accepting through a referral, accepting through a facility or hospital, and not accepting new patients
- **Other information requested in this file**

HEALTH NETWORKS

All HNs and subdelegates shall promptly, but no later than five business days from a change in the practitioner's panel status, inform CalOptima Health of such change. The HN, on a quarterly basis, verifies and updates the practitioner's information. The HN verification process includes a methodology to audit and confirm that the information provided by its practitioners is true and correct. HN maintains records of such verifications and shall provide them during the second and fourth quarters of the year.



CalOptima Health

Add, Change and Termination Form

It is recommended that this form be used to report any additions, changes and/or terminations to a provider's network affiliates.
If this form is being used, a separate form must be completed for each contracted provider being terminated or whose status is changing.

Health Network Name:

Program (Check all that apply): ☐ Medi-Cal ☐ OneCare ☐ PACE

PROVIDER INFORMATION

PROVIDER STATE LICENSE #		PROVIDER TIN #	
TYPE 1 NPI (National Provider ID #)	PROVIDER ID	MEDICARE #	MEDI-CAL EFFECTIVE DATE
PROVIDER NAME (Last)	(First)		(Middle Initial)
PRIMARY TAXONOMY	SECONDARY TAXONOMY	TERTIARY TAXONOMY	ORDERING, REFERRING, PRESCRIBING (ORP) ☐ YES ☐ NO
AREA OF FOCUS	PRIMARY SPECIALTY	SECONDARY SPECIALTY	
GROUP NAME	PROVIDER TELEHEALTH INDICATORS ☐ Telehealth Only ☐ No Telehealth ☐ Both Telehealth and In-person		
GROUP/TYPE 2 NPI (National Provider ID #)	GROUP ID	GROUP TIN	
PRIMARY SERVICE ADDRESS FOR AFFILIATION (See Page 2 for address changes and additional locations)		CITY	STATE ZIP
PHONE	AUTHORIZATION/REFERRAL FAX	SERVICE EMAIL ADDRESS	OFFICE MANAGER
REMIT ADDRESS	CITY	STATE ZIP PHONE	FAX
ADMINISTRATION EMAIL ADDRESS	WEBSITE URL ADDRESS	SPECIAL SERVICES ☐ CCS ☐ CPSP	

HOSPITAL/FACILITY AFFILIATIONS AND ADMITTING PRIVILEGES

1.	2.	3.
☐ NONE ☐ ACTIVE ☐ ASSOCIATE STAFF ☐ HONORARY ☐ CONSULTANT ☐ COURTESY ☐ LIMITED ☐ PROVISIONAL ☐ SENIOR ATTENDING ☐ SURGICAL ☐ SUSPENDED	☐ NONE ☐ ACTIVE ☐ ASSOCIATE STAFF ☐ HONORARY ☐ CONSULTANT ☐ COURTESY ☐ LIMITED ☐ PROVISIONAL ☐ SENIOR ATTENDING ☐ SURGICAL ☐ SUSPENDED	☐ NONE ☐ ACTIVE ☐ ASSOCIATE STAFF ☐ HONORARY ☐ CONSULTANT ☐ COURTESY ☐ LIMITED ☐ PROVISIONAL ☐ SENIOR ATTENDING ☐ SURGICAL ☐ SUSPENDED

☐ EMAIL ATTESTATION ON FILE

ACTION REQUIRED (Check all that apply)

☐ NEW ADD OR AFFILIATION

REQUIREMENTS: The Provider Relations (PR) representative must complete this form, including **credentialing information**, for each provider being added as a provider affiliate. In addition, **a copy of the recitation and signature pages from the provider contract and a W-9 form** must be attached. If copies are not attached, the form will be rejected by Provider Data Management Services (PDMS) and returned to the PR representative.

Effective Date (required): | Date Credentialing Completed (within the last three years) | Current Facility Site Review Date (within the last three years)

PROVIDER TYPE: ☐ ANCILLARY/ALLIED HEALTH ☐ PCP ☐ SPECIALIST ☐ ECM ☐ COMMUNITY SUPPORTS

☐ Open Panel ☐ Closed Panel
- Accepting new patients
- Accepting existing patients
- Accepting new patients through referral
- Accepting new patients through a hospital/facility
- Not accepting new patients

☐ CHANGE IN PANEL STATUS

REQUIREMENTS: Panel changes are effective the date of processing.

PROVIDER TYPE (If applicable, check both): ☐ PCP ☐ SPECIALIST ☐ ECM ☐ COMMUNITY SUPPORTS

☐ Open Panel ☐ Closed Panel
- Accepting new patients
- Accepting existing patients
- Accepting new patients through referral
- Accepting new patients through a hospital/facility
- Not accepting new patients

☐ TAX ID CHANGE

REQUIREMENTS: The health network must attach a copy of the provider notification indicating the change of tax ID AND a new W-9 form.

Effective Date of New Tax ID (required): | Previous Tax ID | New Tax ID

CalOptima Health Addition, Change, Term Form
Revised 4/30/13, 8/23/17, 7/2/18, 3/30/21, 7/5/22, 9/17/24

CalOptima Health, A Public Agency

^Optional to answer and not required

ACT FORM INSTRUCTIONS

Please read through these instructions carefully, which specify the exact data content and data format of each column on the roster.

1) Do not change column name, column order, data format and do not add in new columns.
2) Any column left "blank" or null shall be rejected by the health plan.
3) Submit any practitioner (i.e. PCP, specialist, mid-level) participating within your CalOptima Health network.
4) Submit any practice location (medical office, clinic, etc.) participating within you CalOptima Health network.
5) Submit any hospital that provides health care services to CalOptima Health members within your network, regardless of CalOptima Health contractual relationship.
6) Submit any ancillary facility and its affiliated practitioners that provides health care services to CalOptima Health members within your network, regardless of CalOptima Health contractual relationship.
7) All provider types (taxonomy and specialty):
   a. Must be credentialed
   b. Only the taxonomy and specialty that are contracted at the location
   c. Please refer to the taxonomy codes submitted on the sFTP for taxonomy code table
8) Practice locations must pass Facility Site Review (FSR) - Physician and mid-level.
9) ACT Form submissions that deviate from the criteria listed above will be REJECTED and returned.
10) E-mail completed ACT form and required support documents to ProviderOnline@caloptima.org.

CalOptima Health User Guide

ADD, CHANGE AND TERMINATION (ACT) FORM

HOW TO SUBMIT CALOPTIMA HEALTH ACT FORM

1) Complete all relevant sections of the CalOptima Health ACT Form
2) Attach a competed and signed W9
3) Include a copy of the front of your HN contract and signature page or CCN/COD Contract Summary
4) Complete a provider profile that includes the information listed below
5) E-mail completed ACT form and required support documents to ProviderOnline@caloptima.org
6) For questions and more information, call the CalOptima Health Provider Relations department at **714-246-8600**

Scope of Provider Type

1) **Physician** (individual)
   - Medical Doctor (M.D.)
   - Doctor of Osteopathic Medicine (D.O.)
   - Doctor of Podiatric Medicine (D.P.M.)

(2) **Mid-level** (individual)
   - Certified Nurse Practitioners (CNP)
   - Certified Nurse Midwifes (CNM)
   - Physician Assistants (PA)

(3) **Hospital**: Any hospital within the HN network, regardless of CalOptima Health's contractual relationship. Samples include, but are not limited to the following:

- Ambulatory surgery center
- Hospital with acute care
- Psychiatry hospital

(4) **Ancillary**: Any facility that provides health care services to CalOptima Health members within the HN, regardless of CalOptima Health-contractual relationship. Examples include but are not limited to the following:

- Adult day health care center/community base adult service
- Audiology
- Durable Medical Equipment
- End-stage renal disease provider/dialysis unit/hemodialysis
- Home health
- Home infusion
- Hospice
- Clinical laboratory
- Long-term services and supports
- Occupational therapy
- Physical therapy
- Portable X-ray supplier
- Radiology center
- Rehabilitation center
- Skilled nursing facility
- Transportation services
- Urgent care

… and others

Practitioner Practices at Ancillary (individual) – examples include are but not limited to the following:

- Acupuncturist
- Audiologist
- Chiropractor
- Physical therapist
- Radiation therapist
- Occupational therapist
- Speech therapist

… and others

CalOptima Health User Guide

ADD, CHANGE AND TERMINATION (ACT) FORM

WHEN SHOULD I SUBMIT AN ACT REQUEST?

Additions: Term referred to in the ACT process to add a provider, practitioner or facility to CalOptima Health's system. HNs and subdelegates shall submit ACT forms and required documentation as outlined in this policy when adding a provider, practitioner or facility pursuant to the terms of the agreement. To add an additional location to an existing provider, please check the additional location box on Page 2 of the ACT form.

Changes: Term referred to in the ACT process to make a demographic or other change to a provider, practitioner or facility in CalOptima Health's system. HNs and subdelegates shall submit ACT forms and required documentation as outlined in this policy when making demographic or other changes to the CalOptima Health system pursuant to the terms of the agreement.

Terminations: Term referred to in the ACT process when terminating a provider, practitioner or facility from CalOptima Health's system. HNs and subdelegates shall submit notification of terminations pursuant to the terms of the agreement.

ADDITIONAL SUBMISSION REQUIREMENTS

Additions: When making an addition request, the group name, National Provider Identifier (NPI) and Tax Identification Number (TIN) must all correspond. In the event your submission consists of non-corresponding identifiers, it will not be honored.

Terminations: When requesting a termination of a provider's TIN, you must submit the group NPI along with the TIN.

Health Networks and Subdelegates

- Health networks and providers must take the following steps when requesting to move a provider from one group NPI to another group NPI:
    1. Submit ACT Termination form to remove the provider from the CalOptima Health system
    2. Submit ACT Addition form and required documentation as outlined in EE.1101 to add the provider to the CalOptima Health system with the new group NPI

    Note: Each of the above steps must be done separately.
- If you are adding or changing the address of a primary care provider (PCP), you must include the date of request along with a Facility Site Review (FSR) completion form with your submission request.

E-mail completed ACT form and required support documents to ProviderOnline@caloptima.org

Disclaimer – CalOptima Health will limit the registration of office locations outside of Orange County to only those that are addressing network adequacy and member access gaps unless indicated otherwise within the contract.

Sample Addition

Add, Change and Termination Form

It is recommended that this form be used to report any additions, changes and/or terminations to a provider's network affiliates.
If this form is being used, a separate form must be completed for each contracted provider being terminated or whose status is changing.

Health Network Name:

Program (Check all that apply): ☐ Medi-Cal ☐ OneCare ☐ PACE

PROVIDER INFORMATION

PROVIDER STATE LICENSE #		PROVIDER TIN #	
TYPE 1 NPI (National Provider ID #)	PROVIDER ID	MEDICARE #	MEDI-CAL EFFECTIVE DATE
PROVIDER NAME (Last)	(First)	(Middle Initial)	
PRIMARY TAXONOMY	SECONDARY TAXONOMY	TERTIARY TAXONOMY	ORDERING, REFERRING, PRESCRIBING (ORP) ☐ YES ☐ NO
AREA OF FOCUS	PRIMARY SPECIALTY	SECONDARY SPECIALTY	
GROUP NAME	PROVIDER TELEHEALTH INDICATORS ☐ Telehealth Only ☐ No Telehealth ☐ Both Telehealth and In-person		
GROUP/TYPE 2 NPI (National Provider ID #)	GROUP ID	GROUP TIN	
PRIMARY SERVICE ADDRESS FOR AFFILIATION (See Page 2 for address changes and additional locations)	CITY	STATE	ZIP
PHONE	AUTHORIZATION/REFERRAL FAX	SERVICE EMAIL ADDRESS	OFFICE MANAGER
REMIT ADDRESS	CITY	STATE / ZIP	PHONE / FAX
ADMINISTRATION EMAIL ADDRESS	WEBSITE URL ADDRESS	SPECIAL SERVICES ☐ CCS ☐ CPSP	

HOSPITAL/FACILITY AFFILIATIONS AND ADMITTING PRIVILEGES

1. _____	2. _____	3. _____
☐ NONE ☐ ACTIVE ☐ ASSOCIATE STAFF	☐ NONE ☐ ACTIVE ☐ ASSOCIATE STAFF	☐ NONE ☐ ACTIVE ☐ ASSOCIATE STAFF
☐ HONORARY ☐ CONSULTANT	☐ HONORARY ☐ CONSULTANT	☐ HONORARY ☐ CONSULTANT
☐ COURTESY ☐ LIMITED ☐ PROVISIONAL	☐ COURTESY ☐ LIMITED ☐ PROVISIONAL	☐ COURTESY ☐ LIMITED ☐ PROVISIONAL
☐ SENIOR ATTENDING ☐ SURGICAL	☐ SENIOR ATTENDING ☐ SURGICAL	☐ SENIOR ATTENDING ☐ SURGICAL
☐ SUSPENDED	☐ SUSPENDED	☐ SUSPENDED

☐ EMAIL ATTESTATION ON FILE

ACTION REQUIRED (Check all that apply)

☐ NEW ADD OR AFFILIATION

REQUIREMENTS: The Provider Relations (PR) representative must complete this form, including **credentialing information**, for each provider being added as a provider affiliate. In addition, **a copy of the recitation and signature pages from the provider contract and a W-9 form** must be attached. If copies are not attached, the form will be rejected by Provider Data Management Services (PDMS) and returned to the PR representative.

Effective Date **(required)**:	Date Credentialing Completed (within the last three years)	Current Facility Site Review Date (within the last three years)

PROVIDER TYPE

- ☐ ANCILLARY/ALLIED HEALTH
- ☐ PCP
- ☐ SPECIALIST
- ☐ ECM
- ☐ COMMUNITY SUPPORTS

☐ Open Panel ☐ Closed Panel

- ☐ Accepting new patients
- ☐ Accepting existing patients
- ☐ Accepting new patients through referral
- ☐ Accepting new patients through a hospital/facility
- ☐ Not accepting new patients

☐ CHANGE IN PANEL STATUS

PROVIDER TYPE (If applicable, check both)

REQUIREMENTS: Panel changes are effective the date of processing.

- ☐ PCP
- ☐ SPECIALIST
- ☐ ECM
- ☐ COMMUNITY SUPPORTS

☐ Open Panel ☐ Closed Panel

- ☐ Accepting new patients
- ☐ Accepting existing patients
- ☐ Accepting new patients through referral
- ☐ Accepting new patients through a hospital/facility
- ☐ Not accepting new patients

☐ TAX ID CHANGE

REQUIREMENTS: The health network must attach a copy of the provider notification indicating the change of tax ID AND a new W-9 form.

Effective Date of New Tax ID (required):	Previous Tax ID	New Tax ID

^Optional to answer and not required

CalOptima Health User Guide

ADD, CHANGE AND TERMINATION (ACT) FORM

ACTION REQUIREMENTS (cont.) (Check all that apply)

☐ TERMINATION

REQUIREMENTS: Complete this form for each provider being terminated from its provider network affiliates. If the termination is requested by the provider, a copy of the request from the provider must be attached. If a copy is not attached, the form will be rejected by PDMS and returned to the PR representative.

Effective date (required):	☐ PCP ☐ SPECIALIST ☐ ANCILLARY

Date CalOptima Health received the termination notice:

Exceptions: Review found that the termed specialist is exempt from providing continued access based on the exemption checked below.

- ☐ Provider not available
- ☐ Provider retired
- ☐ Contract not continued
- ☐ Other: _____
- ☐ Provider deceased
- ☐ Provider unwilling to accept member/payment terms
- ☐ Termed due to review action

PCP Termination: Assign member to new PCP: _____
Name of new PCP

Number of members impacted (as of date received): ☐ **Medi-Cal** _____ ☐ **OneCare** _____

Date member notice was mailed (if member notice has not been sent, please put anticipated date and notify CalOptima Health if date changes):

Number of days' notice provider gave to MCP:

☐ ADDRESS/PHONE CHANGE OR ADDITIONAL LOCATION

REQUIREMENTS: For all address changes, select [TERM] to remove an old/prior address and select [ADD] to add the new location. For additional location, select [ADD] to add the additional location. If PCP site, a facility site review is required. A copy of documentation submitted by the provider AND a new W-9 form must be attached, if applicable. Note: The form contains three address sections, allowing multiple changes to be entered for one provider on the same form.

SERVICE ADDRESS **Check one: [ ] ADD [ ] TERM**	Effective Date (required):	SITE TELEHEATH INDICATORS ☐ Telehealth Only ☐ No Telehealth ☐ Both Telehealth and In-Person		
Address		City	State	ZIP
Phone	Authorization/Referral Fax	Office Hours	After Hours Phone	
Office Manager		Email Address		

SERVICE ADDRESS **Check one: [ ] ADD [ ] TERM**	Effective Date (required):	SITE TELEHEATH INDICATORS ☐ Telehealth Only ☐ No Telehealth ☐ Both Telehealth and In-person		
Address		City	State	Zip
Phone Number	Authorization/Referral Fax	Office Hours	After Hours Phone Number	
Office Manager		Email Address		

☐ LANGUAGE

Languages Spoken by Staff

1. _____ 2. _____ 3. _____

Languages spoken by Provider, if fluent with communicating about medical care, put an asterisk next to the language (^ Language fluency is optional to disclose and not required)

1. _____ 2. _____ 3. _____

4. _____ 5 _____ 6. _____

Language services, such as American Sign Language (ASL), and interpreter services
Check all that apply

- ☐ In-office ASL interpreter
- ☐ In-office medical interpreter
- ☐ Other type of in-office interpreter service, fill in here _____

☐ Race/Ethnicity

^ Race/ethnicity of provider. Check all that apply:

- ☐ American Indian Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Hispanic or Latino
- ☐ Middle Eastern or North African
- ☐ Native Hawaiian or Pacific Islander
- ☐ White
- ☐ Choose not to share

☐ Gender-Affirming Care

^ Gender-Affirming Care services that the provider offers. Check all that apply:

- ☐ Voice Therapy
- ☐ Behavioral Health
- ☐ Endocrinology
- ☐ Pediatric Endocrinology
- ☐ Primary Care
- ☐ Hormone Replacement Therapy
- ☐ Electrolysis
- ☐ Laser
- ☐ Adolescent Medicine
- ☐ Voice Surgery
- ☐ Facial Surgery
- ☐ Body Contouring
- ☐ Plastic Surgery
- ☐ Bottom Gynecologist
- ☐ Bottom Reconstruct Urology
- ☐ Surgery Urology
- ☐ Top Surgery
- ☐ Dermatology

Consent to display "Gender-Affirming Care" in the Provider Directory ☐ **YES** ☐ **NO**

^Optional to answer and not required

☐ OTHER	Comments:
PROVIDER RELATIONS REPRESENTATIVE (Please print)	
PROVIDER NAME (Please print)	
SIGNATURE	DATE

^Optional to answer and not required

CalOptima Health User Guide

ADD, CHANGE AND TERMINATION (ACT) FORM

Sample Change

Add, Change and Termination Form

It is recommended that this form be used to report any additions, changes and/or terminations to a provider's network affiliates.
If this form is being used, a separate form must be completed for each contracted provider being terminated or whose status is changing.

Health Network Name:

Program (Check all that apply): ☐ Medi-Cal ☐ OneCare ☐ PACE

PROVIDER INFORMATION

PROVIDER STATE LICENSE #		PROVIDER TIN #	
TYPE 1 NPI (National Provider ID #)	PROVIDER ID	MEDICARE #	MEDI-CAL EFFECTIVE DATE
PROVIDER NAME (Last)	(First)	(Middle Initial)	
PRIMARY TAXONOMY	SECONDARY TAXONOMY	TERTIARY TAXONOMY	ORDERING, REFERRING, PRESCRIBING (ORP) ☐ YES ☐ NO
AREA OF FOCUS	PRIMARY SPECIALTY	SECONDARY SPECIALTY	
GROUP NAME	PROVIDER TELEHEALTH INDICATORS ☐ Telehealth Only ☐ No Telehealth ☐ Both Telehealth and In-person		
GROUP/TYPE 2 NPI (National Provider ID #)	GROUP ID	GROUP TIN	
PRIMARY SERVICE ADDRESS FOR AFFILIATION (See Page 2 for address changes and additional locations)		CITY	STATE ZIP
PHONE	AUTHORIZATION/REFERRAL FAX	SERVICE EMAIL ADDRESS	OFFICE MANAGER
REMIT ADDRESS	CITY	STATE ZIP	PHONE FAX
ADMINISTRATION EMAIL ADDRESS	WEBSITE URL ADDRESS	SPECIAL SERVICES ☐ CCS ☐ CPSP	

HOSPITAL/FACILITY AFFILIATIONS AND ADMITTING PRIVILEGES

1. _____	2. _____	3. _____
☐ NONE ☐ ACTIVE ☐ ASSOCIATE STAFF	☐ NONE ☐ ACTIVE ☐ ASSOCIATE STAFF	☐ NONE ☐ ACTIVE ☐ ASSOCIATE STAFF
☐ HONORARY ☐ CONSULTANT	☐ HONORARY ☐ CONSULTANT	☐ HONORARY ☐ CONSULTANT
☐ COURTESY ☐ LIMITED ☐ PROVISIONAL	☐ COURTESY ☐ LIMITED ☐ PROVISIONAL	☐ COURTESY ☐ LIMITED ☐ PROVISIONAL
☐ SENIOR ATTENDING ☐ SURGICAL	☐ SENIOR ATTENDING ☐ SURGICAL	☐ SENIOR ATTENDING ☐ SURGICAL
☐ SUSPENDED	☐ SUSPENDED	☐ SUSPENDED

☐ EMAIL ATTESTATION ON FILE

ACTION REQUIRED (Check all that apply)

☐ NEW ADD OR AFFILIATION

REQUIREMENTS: The Provider Relations (PR) representative must complete this form, including **credentialing information**, for each provider being added as a provider affiliate. In addition, **a copy of the recitation and signature pages from the provider contract and a W-9 form** must be attached. If copies are not attached, the form will be rejected by Provider Data Management Services (PDMS) and returned to the PR representative.

Effective Date **(required)**:	Date Credentialing Completed (within the last three years)	Current Facility Site Review Date (within the last three years)

PROVIDER TYPE

- ☐ ANCILLARY/ALLIED HEALTH
- ☐ PCP
- ☐ SPECIALIST
- ☐ ECM
- ☐ COMMUNITY SUPPORTS

☐ Open Panel ☐ Closed Panel

- ☐ Accepting new patients
- ☐ Accepting existing patients
- ☐ Accepting new patients through referral
- ☐ Accepting new patients through a hospital/facility
- ☐ Not accepting new patients

☐ CHANGE IN PANEL STATUS

PROVIDER TYPE (If applicable, check both)

REQUIREMENTS: Panel changes are effective the date of processing.

- ☐ PCP
- ☐ SPECIALIST
- ☐ ECM
- ☐ COMMUNITY SUPPORTS

☐ Open Panel ☐ Closed Panel

- ☐ Accepting new patients
- ☐ Accepting existing patients
- ☐ Accepting new patients through referral
- ☐ Accepting new patients through a hospital/facility
- ☐ Not accepting new patients

☐ TAX ID CHANGE

REQUIREMENTS: The health network must attach a copy of the provider notification indicating the change of tax ID AND a new W-9 form.

Effective Date of New Tax ID (required):	Previous Tax ID	New Tax ID

^Optional to answer and not required

CalOptima Health User Guide

ADD, CHANGE AND TERMINATION (ACT) FORM

ACTION REQUIREMENTS (cont.) (Check all that apply)

☐ TERMINATION

REQUIREMENTS: Complete this form for each provider being terminated from its provider network affiliates. If the termination is requested by the provider, a copy of the request from the provider must be attached. If a copy is not attached, the form will be rejected by PDMS and returned to the PR representative.

Effective date (required):	☐ PCP ☐ SPECIALIST ☐ ANCILLARY

Date CalOptima Health received the termination notice:

Exceptions: Review found that the termed specialist is exempt from providing continued access based on the exemption checked below.

- ☐ Provider not available
- ☐ Provider retired
- ☐ Contract not continued
- ☐ Other: _____
- ☐ Provider deceased
- ☐ Provider unwilling to accept member/payment terms
- ☐ Termed due to review action

PCP Termination: Assign member to new PCP: _____
Name of new PCP

Number of members impacted (as of date received): ☐ **Medi-Cal** _____ ☐ **OneCare** _____

Date member notice was mailed (if member notice has not been sent, please put anticipated date and notify CalOptima Health if date changes):

Number of days' notice provider gave to MCP:

☐ ADDRESS/PHONE CHANGE OR ADDITIONAL LOCATION

REQUIREMENTS: For all address changes, select [TERM] to remove an old/prior address and select [ADD] to add the new location. For additional location, select [ADD] to add the additional location. If PCP site, a facility site review is required. A copy of documentation submitted by the provider AND a new W-9 form must be attached, if applicable. Note: The form contains three address sections, allowing multiple changes to be entered for one provider on the same form.

SERVICE ADDRESS **Check one: [ ] ADD [ ] TERM**	Effective Date (required):	SITE TELEHEATH INDICATORS ☐ Telehealth Only ☐ No Telehealth ☐ Both Telehealth and In-Person	
Address		City	State / ZIP
Phone	Authorization/Referral Fax	Office Hours	After Hours Phone
Office Manager		Email Address	

SERVICE ADDRESS **Check one: [ ] ADD [ ] TERM**	Effective Date (required):	SITE TELEHEATH INDICATORS ☐ Telehealth Only ☐ No Telehealth ☐ Both Telehealth and In-person	
Address		City	State / Zip
Phone Number	Authorization/Referral Fax	Office Hours	After Hours Phone Number
Office Manager		Email Address	

☐ LANGUAGE

Languages Spoken by Staff

1. _____ 2. _____ 3. _____

Languages spoken by Provider, if fluent with communicating about medical care, put an asterisk next to the language (^ Language fluency is optional to disclose and not required)

1. _____ 2. _____ 3. _____

4. _____ 5 _____ 6. _____

Language services, such as American Sign Language (ASL), and interpreter services
Check all that apply

- ☐ In-office ASL interpreter
- ☐ In-office medical interpreter
- ☐ Other type of in-office interpreter service, fill in here _____

☐ Race/Ethnicity

^ Race/ethnicity of provider. Check all that apply:

- ☐ American Indian Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Hispanic or Latino
- ☐ Middle Eastern or North African
- ☐ Native Hawaiian or Pacific Islander
- ☐ White
- ☐ Choose not to share

☐ Gender-Affirming Care

^ Gender-Affirming Care services that the provider offers. Check all that apply:

- ☐ Voice Therapy
- ☐ Behavioral Health
- ☐ Endocrinology
- ☐ Pediatric Endocrinology
- ☐ Primary Care
- ☐ Hormone Replacement Therapy
- ☐ Electrolysis
- ☐ Laser
- ☐ Adolescent Medicine
- ☐ Voice Surgery
- ☐ Facial Surgery
- ☐ Body Contouring
- ☐ Plastic Surgery
- ☐ Bottom Gynecologist
- ☐ Bottom Reconstruct Urology
- ☐ Surgery Urology
- ☐ Top Surgery
- ☐ Dermatology

Consent to display "Gender-Affirming Care" in the Provider Directory ☐ **YES** ☐ **NO**

^Optional to answer and not required

☐ OTHER

Comments:

PROVIDER RELATIONS REPRESENTATIVE (Please print)	
PROVIDER NAME (Please print)	
SIGNATURE	DATE

CalOptima Health User Guide

ADD, CHANGE AND TERMINATION (ACT) FORM

Sample Termination

Add, Change and Termination Form

It is recommended that this form be used to report any additions, changes and/or terminations to a provider's network affiliates.
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Health Network Name:

Program (Check all that apply): ☐ Medi-Cal ☐ OneCare ☐ PACE

PROVIDER INFORMATION

PROVIDER STATE LICENSE #		PROVIDER TIN #	
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PROVIDER NAME (Last)	(First)		(Middle Initial)
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AREA OF FOCUS	PRIMARY SPECIALTY	SECONDARY SPECIALTY	
GROUP NAME	PROVIDER TELEHEALTH INDICATORS ☐ Telehealth Only ☐ No Telehealth ☐ Both Telehealth and In-person		
GROUP/TYPE 2 NPI (National Provider ID #)	GROUP ID	GROUP TIN	
PRIMARY SERVICE ADDRESS FOR AFFILIATION (See Page 2 for address changes and additional locations)		CITY	STATE ZIP
PHONE	AUTHORIZATION/REFERRAL FAX	SERVICE EMAIL ADDRESS	OFFICE MANAGER
REMIT ADDRESS	CITY	STATE ZIP	PHONE FAX
ADMINISTRATION EMAIL ADDRESS	WEBSITE URL ADDRESS	SPECIAL SERVICES ☐ CCS ☐ CPSP	

HOSPITAL/FACILITY AFFILIATIONS AND ADMITTING PRIVILEGES		
1. _____	2. _____	3. _____
☐ NONE ☐ ACTIVE ☐ ASSOCIATE STAFF	☐ NONE ☐ ACTIVE ☐ ASSOCIATE STAFF	☐ NONE ☐ ACTIVE ☐ ASSOCIATE STAFF
☐ HONORARY ☐ CONSULTANT	☐ HONORARY ☐ CONSULTANT	☐ HONORARY ☐ CONSULTANT
☐ COURTESY ☐ LIMITED ☐ PROVISIONAL	☐ COURTESY ☐ LIMITED ☐ PROVISIONAL	☐ COURTESY ☐ LIMITED ☐ PROVISIONAL
☐ SENIOR ATTENDING ☐ SURGICAL	☐ SENIOR ATTENDING ☐ SURGICAL	☐ SENIOR ATTENDING ☐ SURGICAL
☐ SUSPENDED	☐ SUSPENDED	☐ SUSPENDED

☐ EMAIL ATTESTATION ON FILE

ACTION REQUIRED (Check all that apply)

☐ NEW ADD OR AFFILIATION

REQUIREMENTS: The Provider Relations (PR) representative must complete this form, including **credentialing information**, for each provider being added as a provider affiliate. In addition, **a copy of the recitation and signature pages from the provider contract and a W-9 form** must be attached. If copies are not attached, the form will be rejected by Provider Data Management Services (PDMS) and returned to the PR representative.

Effective Date **(required)**:	Date Credentialing Completed (within the last three years)	Current Facility Site Review Date (within the last three years)
PROVIDER TYPE	☐ **ANCILLARY/ALLIED HEALTH** ☐ **PCP** ☐ **SPECIALIST** ☐ **ECM** ☐ **COMMUNITY SUPPORTS**	☐ **Open Panel** ☐ **Closed Panel** ☐ Accepting new patients ☐ Accepting existing patients ☐ Accepting new patients through referral ☐ Accepting new patients through a hospital/facility ☐ Not accepting new patients

☐ CHANGE IN PANEL STATUS

REQUIREMENTS: Panel changes are effective the date of processing.

PROVIDER TYPE (If applicable, check both)		
	☐ **PCP** ☐ **SPECIALIST** ☐ **ECM** ☐ **COMMUNITY SUPPORTS**	☐ **Open Panel** ☐ **Closed Panel** ☐ Accepting new patients ☐ Accepting existing patients ☐ Accepting new patients through referral ☐ Accepting new patients through a hospital/facility ☐ Not accepting new patients

☐ TAX ID CHANGE

REQUIREMENTS: The health network must attach a copy of the provider notification indicating the change of tax ID AND a new W-9 form.

Effective Date of New Tax ID (required):	Previous Tax ID	New Tax ID

^Optional to answer and not required

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ADD, CHANGE AND TERMINATION (ACT) FORM

ACTION REQUIREMENTS (cont.) (Check all that apply)

☐ TERMINATION

REQUIREMENTS: Complete this form for each provider being terminated from its provider network affiliates. If the termination is requested by the provider, a copy of the request from the provider must be attached. If a copy is not attached, the form will be rejected by PDMS and returned to the PR representative.

Effective date (required): ☐ PCP ☐ SPECIALIST ☐ ANCILLARY

Date CalOptima Health received the termination notice:

Exceptions: Review found that the termed specialist is exempt from providing continued access based on the exemption checked below.

- ☐ Provider not available
- ☐ Provider retired
- ☐ Contract not continued
- ☐ Other: _____
- ☐ Provider deceased
- ☐ Provider unwilling to accept member/payment terms
- ☐ Termed due to review action

PCP Termination: Assign member to new PCP: _____
Name of new PCP

Number of members impacted (as of date received): ☐ Medi-Cal _____ ☐ OneCare _____

Date member notice was mailed (if member notice has not been sent, please put anticipated date and notify CalOptima Health if date changes):

Number of days' notice provider gave to MCP:

☐ ADDRESS/PHONE CHANGE OR ADDITIONAL LOCATION

REQUIREMENTS: For all address changes, select [TERM] to remove an old/prior address and select [ADD] to add the new location. For additional location, select [ADD] to add the additional location. If PCP site, a facility site review is required. A copy of documentation submitted by the provider AND a new W-9 form must be attached, if applicable. Note: The form contains three address sections, allowing multiple changes to be entered for one provider on the same form.

SERVICE ADDRESS **Check one: [ ] ADD [ ] TERM**	Effective Date (required):	SITE TELEHEATH INDICATORS ☐ Telehealth Only ☐ No Telehealth ☐ Both Telehealth and In-Person		
Address		City	State	ZIP
Phone	Authorization/Referral Fax	Office Hours	After Hours Phone	
Office Manager		Email Address		
SERVICE ADDRESS **Check one: [ ] ADD [ ] TERM**	Effective Date (required):	SITE TELEHEATH INDICATORS ☐ Telehealth Only ☐ No Telehealth ☐ Both Telehealth and In-person		
Address		City	State	Zip
Phone Number	Authorization/Referral Fax	Office Hours	After Hours Phone Number	
Office Manager		Email Address		

☐ LANGUAGE

Languages Spoken by Staff

1. _____ 2. _____ 3. _____

Languages spoken by Provider, if fluent with communicating about medical care, put an asterisk next to the language (^ Language fluency is optional to disclose and not required)

1. _____ 2. _____ 3. _____

4. _____ 5 _____ 6. _____

Language services, such as American Sign Language (ASL), and interpreter services
Check all that apply

- ☐ In-office ASL interpreter
- ☐ In-office medical interpreter
- ☐ Other type of in-office interpreter service, fill in here _____

☐ Race/Ethnicity

^ Race/ethnicity of provider. Check all that apply:

- ☐ American Indian Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Hispanic or Latino
- ☐ Middle Eastern or North African
- ☐ Native Hawaiian or Pacific Islander
- ☐ White
- ☐ Choose not to share

☐ Gender-Affirming Care

^ Gender-Affirming Care services that the provider offers. Check all that apply:

- ☐ Voice Therapy
- ☐ Behavioral Health
- ☐ Endocrinology
- ☐ Pediatric Endocrinology
- ☐ Primary Care
- ☐ Hormone Replacement Therapy
- ☐ Electrolysis
- ☐ Laser
- ☐ Adolescent Medicine
- ☐ Voice Surgery
- ☐ Facial Surgery
- ☐ Body Contouring
- ☐ Plastic Surgery
- ☐ Bottom Gynecologist
- ☐ Bottom Reconstruct Urology
- ☐ Surgery Urology
- ☐ Top Surgery
- ☐ Dermatology

Consent to display "Gender-Affirming Care" in the Provider Directory ☐ YES ☐ NO

^Optional to answer and not required

☐ OTHER

Comments:

PROVIDER RELATIONS REPRESENTATIVE
(Please print)

PROVIDER NAME
(Please print)

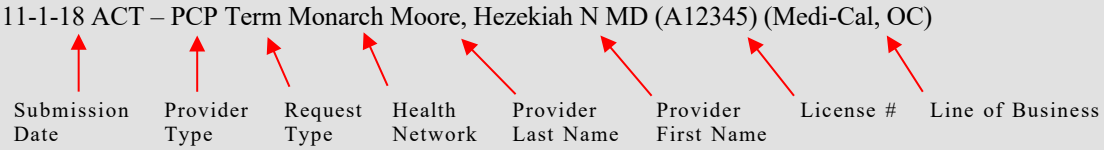
SIGNATURE	DATE

ADDENDUM

CalOptima Health requests use of the email header naming convention reflected below to ensure compliance with turnaround guidelines. Please use the headers below; do not add "Urgent" or deviate from the headers below.

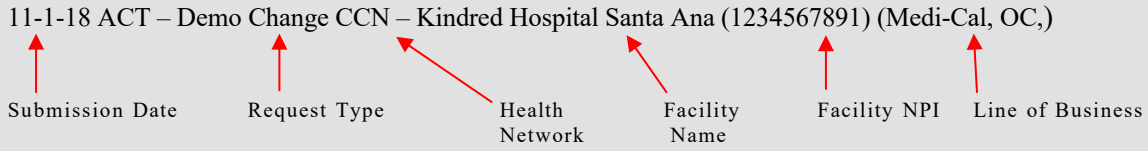
Naming Convention for Email Subject Headers

Provider



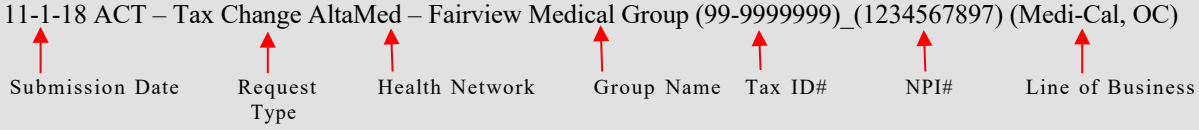
Provider email subject header naming convention:
Submission Date: Date form is submitted
Provider Type: PCP, SPC, MIDLEVEL, ANC
Request Type: Add, Change, Term, CAP (Corrective Action Plan)
Health Network Name: Provider health network affiliation
Provider Last Name: Last name of provider based on state license
Provider First Name: First name of provider based on state license
License #: State license number
Line of Business: MC = Medi-Cal, OC = OneCare

Facility



Facility email subject header naming convention:
Submission Date: Date form is submitted
Request Type: Add, Change, Term, CAP (Corrective Action Plan)
Health Network Name: Facility health network affiliation Facility
Name: Facility name as reflected on agreement
Facility NPI: Facility NPI
Line of Business: MC = Medi-Cal, OC = OneCare

Group



Group Email Subject Header Naming Convention:
Submission Date: Date form is submitted
Request Type: Add, Change, Term, CAP (Corrective Action Plan)
Health Network Name: Provider's health network affiliation
Group Name: Name of group as reflected on agreement
Tax-ID: Group Tax ID on accompanying W-9
NPI #: Type 2 NPI

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ADD, CHANGE AND TERMINATION (ACT) FORM

DEFINITIONS

HEALTH NETWORK NAME	Health network group name
LINE OF BUSINESS	The program/product code the practitioner affiliates with CalOptima Health at the practice location. Lines of business codes include: MC = Medi-Cal; OC = OneCare; PACE = PACE. If practitioner has more than one program, insert additional line of business records (rows) for each program.
CA LICENSE NUMBER	California license number of the practitioner. Catenate the license type letter (NP, CNM and PA for mid-level; A, C, G, and 20A for MD and DO; E for DPM) and license number together and no space in between.
PROVIDER TIN	The individual federal tax ID of the practitioner. Note: It is NOT a provider group, IPA or location's TIN. Numbers only - no space and no special characters.
TYPE 1 NPI	National provider identifier of the practitioner (NPI type 1, 10 digits).
PROVIDER ID	The individual identification number assigned by CalOptima to be used for existing providers for demographic changes and terminations (9 digits = solo practitioner; 12 digits = affiliated to a group).
MEDICARE NUMBER	CMS Certification Number is used to verify that a provider has been Medicare-/Medicaid-certified and for what type of services. Formerly it was known as 1) OSCAR provider number 2) Medicare Identification Number or 3) Medicare/Medicaid Identification Number. Reference: CMS Manual System, Pub 100-07 State Operations Provider Certification.
MEDI-CAL EFFECTIVE DATE	Effective date the provider received a Medicaid provider number.
PROVIDER LAST NAME	Full last name attached to the practitioner's professional license issued by the State of California. For practitioners not subject to state licensure, such as certain qualified autism service providers, it means the last name appearing on the certification by a national entity.
PROVIDER FIRST NAME	Full first name attached to the practitioner's professional license issued by the State of California. For practitioners not subject to state licensure, such as certain qualified autism service providers, it means the first name appearing on the certification by a national entity.
PROVIDER MIDDLE NAME	Full middle name attached to the practitioner's professional license issued by the State of California. For practitioners not subject to state licensure, such as certain qualified autism service providers, it means the middle name appearing on the certification by a national entity.
TAXONOMY (PRIMARY, SECONDARY, TERTIARY)	The taxonomy code of the specialty for which the practitioner has. Please refer to the taxonomy crosswalk provided by CalOptima Health.
FACILITY PHYSICAL ACCESSIBILITY COMPLIANCE	Meets facility American Disability Act (ADA) handicapped compliance.
ORDERING, REFERRING, PRESCRIBING (ORP)	State or federal regulated certification for providers who order, refer or prescribe.
AREA OF FOCUS	The specific focus of the practitioner's specialty.
PRIMARY SPECIALTY	The primary specialty for which the practitioner is contracted to provide services at the location. When providers practice at multiple sites, they may have different primary and secondary specialties for each site based on the contract.

SECONDARY SPECIALTY	The secondary specialty for which the practitioner is contracted to provide services at the location. When providers practice at multiple sites, they may have different primary and secondary specialties for each site based on the contract.
GROUP NAME	Full name of Medical Group practitioner is affiliated with based on contract.
GROUP/TYPE 2 NPI	National provider identifier of the medical group (NPI type 2, 10 digits).
GROUP ID	The identification number assigned by CalOptima Health to be used for existing medical groups for demographic changes and terminations (nine digits).
GROUP TIN	The group federal tax ID of the practitioner. Numbers only — no space and no special characters.
SERVICE LOCATION STREET	USPS CASS-certified delivery address street names and their ranges at the practice location. Must use USPS postal addressing standard (Publication 28). No special characters. No punctuation unless a decimal in number (39.2 RD), fractional addresses (39 1/2 RD) or hyphenated addresses (39-3 RD). A space between secondary designator and range: APT = Apartment; BLDG = Building; FL = Floor; STE = Suite; UNIT = Unit; RM = Room; DEPT = Department.
SERVICE LOCATION CITY	City where the practice location is located. Must be USPS CASS-certified and use USPS postal addressing standard (Publication28).
SERVICE LOCATION COUNTY	County where the practice is located.
SERVICE LOCATION STATE	State where the practice is located. Must be USPS CASS-certified and use USPS postal addressing standard (Publication28)
SERVICE LOCATION ZIP	Zip code in which the practice is located (five digits). Must be USPS CASS-certified and use USPS postal addressing standard (Publication28).
SECONDARY SPECIALTY	The secondary specialty for which the practitioner is contracted to provide services at the location. When providers practice at multiple sites, they may have different primary and secondary specialties for each site based on the contract.
REMIT STREET	USPS CASS-certified pay-to address street names, secondary address unit designators and their ranges for this practice location. Must use USPS postal addressing standard (Publication 28). No special characters. No punctuation unless a decimal in number (39.2 RD), fractional addresses (39 1/2 RD) or hyphenated addresses (39-3 RD). A space between secondary designator and range: APT = Apartment; BLDG = Building; FL = Floor; STE = Suite; UNIT = Unit; RM = Room; DEPT = Department.
REMIT CITY	City where the pay-to is located. Must be USPS CASS-certified and use USPS postal addressing standard (Publication28).
REMIT STATE	State where the pay-to is located. Must be USPS CASS-certified and use USPS postal addressing standard (Publication28).
REMIT ZIP	Zip code in which the pay-to is located (five digits). Must be USPS CASS-certified and use USPS postal addressing standard (Publication28).
OFFICE MANAGER	Name of the contact person at the practice location.
PHONE NUMBER	Phone number at practice location. No space or special character and 10-digit number only.
Authorization/Referral FAX	Fax number at practice location for clinical purposes such as authorizations and referrals requests
SERVICE EMAIL	Email address at the practice location.
ADMINISTRATION EMAIL ADDRESS	Email address the practitioner uses for business correspondence with CalOptima Health only. Note: It is NOT site contact person's email. It is internal use between CalOptima Health and practitioner only.

WEBSITE URL ADDRESS	The website or other online resource for the practice location. Use complete URL syntax including scheme, 2 slashes, authority part and path, with optional query and fragment.
SPECIAL SERVICES	Check all that apply: CCS, CPSP
HOSPITAL / FACILTIY AFFILIATIONS ADMITTING PRIV	The name of CalOptima Health-contracted hospital where the practitioner him/herself is on staff and/or having admitting privilege. Type of privileges includes: NONE, ACTIVE, ASSOCIATE STAFF, HONORARY, CONSULTANT, COURTESY, LIMITED, PROVISIONAL, SENIOR ATTENDING, SURGICAL, SUSPENDED.
ATTESTATION	Yes = HN has received a provider attestation. No = HN has not received a provider attestation. Note it won't be published in provider directory now, but by providing the public email, the provider acknowledges and agrees that the email is for patient communications, regularly monitored, maintained in manner consistent with state and federal health privacy laws, including Health Insurance Portability and Accountability Act (HIPAA) and Confidentiality of Medical Information Act (CMIA).
ACCEPTING NEW PATIENTS	Accepting new patients; No = Not accepting new patients
ACCEPTING EXISTING PATIENTS	Accepting existing patients; No = Not accepting existing patients
ACCEPTING THROUGH REFERRAL	Accepting through referral; No = Not accepting through referral
ACCEPTING THROUGH HOSPITAL FACILITY	Accepting through hospital facility; No = Not accepting through referral
NOT ACCEPTING NEW PATIENTS	Not accepting new patients
PANEL STATUS	The providers panel status is "Open" or "Closed".
OFFICE HOUR SUNDAY	Office hours of the practice location on Sunday. "CLOSED" if not open. Format is "HH:MI-HH:MI", 11 digits exact and no space. HH is between 00 and 23. Ignore lunch closure. If it opens 8:30am-12pm and 1pm-5pm, then put "08:30-17:00".
OFFICE HOUR MONDAY	Office hours of the practice location on Monday. "CLOSED" if not open. Format is "HH:MI-HH:MI", 11 digits exact and no space. HH is between 00 and 23. Ignore lunch closure. If it opens 8:30am-12pm and 1pm-5pm, then put "08:30-17:00".
OFFICE HOUR TUESDAY	Office hours of the practice location on Tuesday. "CLOSED" if not open. Format is "HH:MI-HH:MI", 11 digits exact and no space. HH is between 00 and 23. Ignore lunch closure. If it opens 8:30am-12pm and 1pm-5pm, then put "08:30-17:00".
OFFICE HOUR WEDNESDAY	Office hours of the practice location on Wednesday. "CLOSED" if not open. Format is "HH:MI-HH:MI", 11 digits exact and no space. HH is between 00 and 23. Ignore lunch closure. If it opens 8:30am-12pm and 1pm-5pm, then put "08:30-17:00".
OFFICE HOUR THURSDAY	Office hours of the practice location on Thursday. "CLOSED" if not open. Format is "HH:MI-HH:MI", 11 digits exact and no space. HH is between 00 and 23. Ignore lunch closure. If it opens 8:30am-12pm and 1pm-5pm, then put "08:30-17:00".
OFFICE HOUR FRIDAY	Office hours of the practice location on Friday. "CLOSED" if not open. Format is "HH:MI-HH:MI", 11 digits exact and no space. HH is between 00 and 23. Ignore lunch closure. If it opens 8:30am-12pm and 1pm-5pm, then put "08:30-17:00".
OFFICE HOUR SATURDAY	Office hours of the practice location on Saturday. "CLOSED" if not open. Format is "HH:MI-HH:MI", 11 digits exact and no space. HH is between 00 and 23. Ignore lunch closure. If it opens 8:30am-12pm and 1pm-5pm, then put "08:30-17:00".
SERVICE LOCATION PHONE AFTER-HOURS	Phone number at practice location after hours in case of emergency or urgency. No space or special character and 10-digit number only.
LANGUAGE Spoken by Staff	The language spoken by office staff (not providers) at practice location. Use Language tab.

Language spoken by Provider	The language practitioner speaks including medical fluency. Use Language tab.
MEMBER AGE MIN	Use comments section: CalOptima Health member's minimum age that is allowed at the practice location based on provider's contracted specialty. Age is presented in year and no
MEMBER AGE MAX	Use comments section: CalOptima Health member's maximum age that is allowed at the practice location based on provider's contracted specialty. Age is presented in year and no limit = 150.
GENDER RESTRICTION	Use comments section: If the service at the practice location is only accessible to specific gender of CalOptima Health member. F = female member only; M = male member only; NR = no restriction.
TELEHEALTH SITE INDICATORS	Site indicator: Telehealth Only, No Telehealth, or Both Telehealth and In-Person. Use Telehealth Tab.
RACE/ETHNICITY	The Race/Ethnicity of the Provider
Gender-Affirming Care	Check the Gender-Affirming Care services the provider offers. Include consent status.