

# 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.

### 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](mailto:ProviderOnline@caloptima.org).

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): <input type="checkbox"/> Medi-Cal <input type="checkbox"/> OneCare <input type="checkbox"/> 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) <input type="checkbox"/> YES <input type="checkbox"/> NO
AREA OF FOCUS	PRIMARY SPECIALTY
SECONDARY SPECIALTY	
GROUP NAME	PROVIDER TELEHEALTH INDICATORS
<input type="checkbox"/> Telehealth Only <input type="checkbox"/> No Telehealth <input type="checkbox"/> Both Telehealth and In-person	
GROUP/TYPE 2 NPI (National Provider ID #) / GROUP ID	GROUP TIN
SERVICE ADDRESS FOR AFFILIATION (See Page 2 for address changes and additional locations)	CITY
STATE	ZIP
REMIT ADDRESS	CITY
STATE	ZIP
OFFICE MANAGER	PHONE
FAX	PUBLIC EMAIL ADDRESS
ADMINISTRATION EMAIL ADDRESS	WEBSITE URL ADDRESS
SPECIAL SERVICES <input type="checkbox"/> CCS <input type="checkbox"/> CPSP	
HOSPITAL / FACILITY AFFILIATIONS AND ADMITTING PRIVILEGES	
1. <input type="checkbox"/> NONE <input type="checkbox"/> ACTIVE <input type="checkbox"/> ASSOCIATE STAFF <input type="checkbox"/> HONORARY <input type="checkbox"/> CONSULTANT <input type="checkbox"/> COURTESY <input type="checkbox"/> LIMITED <input type="checkbox"/> PROVISIONAL <input type="checkbox"/> SENIOR ATTENDING <input type="checkbox"/> SURGICAL <input type="checkbox"/> SUSPENDED	2. <input type="checkbox"/> NONE <input type="checkbox"/> ACTIVE <input type="checkbox"/> ASSOCIATE STAFF <input type="checkbox"/> HONORARY <input type="checkbox"/> CONSULTANT <input type="checkbox"/> COURTESY <input type="checkbox"/> LIMITED <input type="checkbox"/> PROVISIONAL <input type="checkbox"/> SENIOR ATTENDING <input type="checkbox"/> SURGICAL <input type="checkbox"/> SUSPENDED
3. <input type="checkbox"/> NONE <input type="checkbox"/> ACTIVE <input type="checkbox"/> ASSOCIATE STAFF <input type="checkbox"/> HONORARY <input type="checkbox"/> CONSULTANT <input type="checkbox"/> COURTESY <input type="checkbox"/> LIMITED <input type="checkbox"/> PROVISIONAL <input type="checkbox"/> SENIOR ATTENDING <input type="checkbox"/> SURGICAL <input type="checkbox"/> SUSPENDED	
<input type="checkbox"/> EMAIL ATTESTATION ON FILE	
ACTION REQUIRED (Check all that apply)	
REQUIREMENTS: The Provider Relations (PR) Representative (Rep) 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 Rep.	
Effective Date (required):	Date Credentialing Completed (within last 3 years)
Current Facility Site Review Date (within last 3 years)	
NEW ADD OR AFFILIATION	PROVIDER TYPE
<input type="checkbox"/> ANCILLARY/ALLIED HEALTH	<input type="checkbox"/> Open Panel / <input type="checkbox"/> Closed Panel
<input type="checkbox"/> PCP	<input type="checkbox"/> Accepting new patients
<input type="checkbox"/> SPECIALIST	<input type="checkbox"/> Accepting existing patients
<input type="checkbox"/> ECM	<input type="checkbox"/> Accepting new patients through referral
<input type="checkbox"/> COMMUNITY SUPPORTS	<input type="checkbox"/> Accepting new patients through a hospital/facility
	<input type="checkbox"/> Not accepting new patients
CHANGE IN PANEL STATUS	PROVIDER TYPE (If applicable, check both)
<input type="checkbox"/> PCP	<input type="checkbox"/> Open Panel / <input type="checkbox"/> Closed Panel
<input type="checkbox"/> SPECIALIST	<input type="checkbox"/> Accepting new patients
<input type="checkbox"/> ECM	<input type="checkbox"/> Accepting existing patients
<input type="checkbox"/> COMMUNITY SUPPORTS	<input type="checkbox"/> Accepting new patients through referral
	<input type="checkbox"/> Accepting new patients through a hospital/facility
	<input type="checkbox"/> 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 I.D. (required):	Previous Tax I.D.
New Tax I.D.	

### HOW TO SUBMIT CALOPTIMA HEALTH ACT FORM

- 1) Complete all relevant sections of the CalOptima Health ACT Form
- 2) Attach a completed 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](mailto: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 Midwives (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:
 

<ul style="list-style-type: none"> <li>• Adult day health care center/community base adult service</li> <li>• Audiology</li> <li>• Durable Medical Equipment</li> <li>• End-stage renal disease provider/dialysis unit/hemodialysis</li> <li>• Home health</li> <li>• Home infusion</li> <li>• Hospice</li> <li>• Clinical laboratory</li> </ul>	<ul style="list-style-type: none"> <li>• Long-term services and supports</li> <li>• Occupational therapy</li> <li>• Physical therapy</li> <li>• Portable X-ray supplier</li> <li>• Radiology center</li> <li>• Rehabilitation center</li> <li>• Skilled nursing facility</li> <li>• Transportation services</li> <li>• Urgent care</li> <li>... and others</li> </ul>
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- Practitioner Practices at Ancillary** (individual) – examples include are but not limited to the following:
- |  |   |
|--|---|
| <ul style="list-style-type: none"> <li>• Acupuncturist</li> <li>• Audiologist</li> <li>• Chiropractor</li> <li>• Physical therapist</li> </ul> | <ul style="list-style-type: none"> <li>• Radiation therapist</li> <li>• Occupational therapist</li> <li>• Speech therapist</li> <li>... and others</li> </ul> |
|--|---|

### 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:
  - Submit ACT Termination form to remove the provider from the CalOptima Health system
  - 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](mailto: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.

CalOptima Health User Guide
ADD, CHANGE AND TERMINATION (ACT) FORM



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 # MEDICAL 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
SERVICE ADDRESS FOR AFFILIATION (See Page 2 for address changes and additional locations) CITY STATE ZIP
REMIT ADDRESS CITY STATE ZIP
OFFICE MANAGER PHONE FAX PUBLIC EMAIL ADDRESS
ADMINISTRATION EMAIL ADDRESS WEBSITE URL ADDRESS SPECIAL SERVICES CCS CPSP
HOSPITAL/FACILITY AFFILIATIONS AND ADMITTING PRIVILEGES
1. NONE ACTIVE ASSOCIATE STAFF HONORARY CONSULTANT COURTESY LIMITED PROVISIONAL SENIOR ATTENDING SURGICAL SUSPENDED
2. NONE ACTIVE ASSOCIATE STAFF HONORARY CONSULTANT COURTESY LIMITED PROVISIONAL SENIOR ATTENDING SURGICAL SUSPENDED
3. 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
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
3 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/affiliation
Not accepting new patients
CHANGE IN PANEL STATUS
PROVIDER TYPE (If applicable, check both)
PCP
3 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/affiliation
Not accepting new patients
TAX ID CHANGE
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)			
<input type="checkbox"/> <b>TERMINATION</b>	<b>REQUIREMENTS:</b> Complete this form for each provider being terminated from its provider network affiliation. 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 PQMIS and returned to the PR representative.		
	Effective date (required):	<input type="checkbox"/> PCP <input type="checkbox"/> SPECIALIST <input type="checkbox"/> ANCILLARY	
	Date CalOptima Health received the termination notice:		
	Exemptions: Review found that the terminated specialist is exempt from providing continued access based on the exemption checked below. <div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> Provider not available  <input type="checkbox"/> Provider leaving  <input type="checkbox"/> Contract not continued  <input type="checkbox"/> Other: _____           </div> <div> <input type="checkbox"/> Provider deceased  <input type="checkbox"/> Provider unwilling to accept member payment terms  <input type="checkbox"/> Termined due to review action           </div> </div>		
	PCP Termination: Assign member to new PCP: _____ <div style="text-align: center;">Name of new PCP</div>		
<input type="checkbox"/> <b>ADDRESS/PHONE CHANGE OR ADDITIONAL LOCATION</b>	<b>REQUIREMENTS:</b> 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.		
	<b>SERVICE ADDRESS</b> Check one: <input type="checkbox"/> [ADD] <input type="checkbox"/> [TERM]	Effective Date (required):	<b>SITE/TELEHEALTH INDICATORS</b> <input type="checkbox"/> Telehealth Only <input type="checkbox"/> No Telehealth <input type="checkbox"/> Both Telehealth and in-person
	Address:		City:   State:   Zip:
	Phone:	Fax:	Office Hours:   After Hours Phone:
	Office Manager:		Email Address:
<b>SERVICE ADDRESS</b> Check one: <input type="checkbox"/> [ADD] <input type="checkbox"/> [TERM]	Effective Date (required):	<b>SITE/TELEHEALTH INDICATORS</b> <input type="checkbox"/> Telehealth Only <input type="checkbox"/> No Telehealth <input type="checkbox"/> Both Telehealth and in-person	
Address:		City:   State:   Zip:	
Phone Number:		Fax Number:	Office Hours:   After Hours Phone Number:
Office Manager:		Email Address:	
<input type="checkbox"/> <b>LANGUAGE</b>	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: <input type="checkbox"/> In-office ASL interpreter <input type="checkbox"/> In-office medical interpreter <input type="checkbox"/> Other type of in-office interpreter service, list in item _____		
<input type="checkbox"/> <b>Race/Ethnicity</b>	* Race/Ethnicity of provider. Check all that apply: <div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> American Indian Alaska Native  <input type="checkbox"/> Asian  <input type="checkbox"/> Black or African American  <input type="checkbox"/> Hispanic or Latino           </div> <div> <input type="checkbox"/> Middle Eastern or North African  <input type="checkbox"/> Native Hawaiian or Pacific Islander  <input type="checkbox"/> White  <input type="checkbox"/> Choose not to share           </div> </div>		
	<b>Comments:</b> <div style="height: 40px;"></div>		
<b>PROVIDER RELATIONS REPRESENTATIVE</b> (Please print)			
<b>PROVIDER NAME</b> (Please print)			
<b>SIGNATURE</b>		<b>DATE</b>	

\*Optional to answer and not required



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### 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.

**Sample  
Change**

<b>Health Network Name:</b>			
<b>Program (Check all that apply):</b> <input type="checkbox"/> Medi-Cal <input type="checkbox"/> OneCare <input type="checkbox"/> PACE			
<b>PROVIDER INFORMATION</b>			
<b>PROVIDER STATE LICENSE #</b>		<b>PROVIDER TIN #</b>	
<b>TYPE 1 NPI (National Provider ID #)</b>	<b>PROVIDER ID</b>	<b>MEDICARE #</b>	<b>MEDICARE EFFECTIVE DATE</b>
<b>PROVIDER NAME (Last)</b>		<b>(First)</b>	<b>(Middle Initial)</b>
<b>PRIMARY TAXONOMY</b>	<b>SECONDARY TAXONOMY</b>	<b>TERTIARY TAXONOMY</b>	<b>ORDERING, REFERRING, PRESCRIBING (ORP)</b> <input type="checkbox"/> YES <input type="checkbox"/> NO
<b>AREA OF FOCUS</b>	<b>PRIMARY SPECIALTY</b>	<b>SECONDARY SPECIALTY</b>	
<b>GROUP NAME</b>		<b>PROVIDER TELEHEALTH INDICATORS</b> <input type="checkbox"/> Telehealth Only <input type="checkbox"/> No Telehealth <input type="checkbox"/> Both Telehealth and In-person	
<b>GROUP TYPE 2 NPI (National Provider ID #)</b>	<b>GROUP ID</b>	<b>GROUP TIN</b>	
<b>SERVICE ADDRESS FOR AFFILIATION (See Page 2 for address changes and additional locations)</b>		<b>CITY</b>	<b>STATE</b> <b>ZIP</b>
<b>REMIT ADDRESS</b>		<b>CITY</b>	<b>STATE</b> <b>ZIP</b>
<b>OFFICE MANAGER</b>	<b>PHONE</b>	<b>FAX</b>	<b>PUBLIC EMAIL ADDRESS</b>
<b>ADMINISTRATION EMAIL ADDRESS</b>	<b>WEBSITE URL ADDRESS</b>	<b>SPECIAL SERVICES</b> <input type="checkbox"/> DCS <input type="checkbox"/> CDSR	
<b>HOSPITAL/FACILITY AFFILIATIONS AND ADMITTING PRIVILEGES</b>			
1. <input type="checkbox"/> NONE <input type="checkbox"/> ACTIVE <input type="checkbox"/> ASSOCIATE STAFF <input type="checkbox"/> HONORARY <input type="checkbox"/> CONSULTANT <input type="checkbox"/> COURTESY <input type="checkbox"/> LIMITED <input type="checkbox"/> PROVISIONAL <input type="checkbox"/> SENIOR ATTENDING <input type="checkbox"/> SURGICAL <input type="checkbox"/> SUSPENDED			
2. <input type="checkbox"/> NONE <input type="checkbox"/> ACTIVE <input type="checkbox"/> ASSOCIATE STAFF <input type="checkbox"/> HONORARY <input type="checkbox"/> CONSULTANT <input type="checkbox"/> COURTESY <input type="checkbox"/> LIMITED <input type="checkbox"/> PROVISIONAL <input type="checkbox"/> SENIOR ATTENDING <input type="checkbox"/> SURGICAL <input type="checkbox"/> SUSPENDED			
3. <input type="checkbox"/> NONE <input type="checkbox"/> ACTIVE <input type="checkbox"/> ASSOCIATE STAFF <input type="checkbox"/> HONORARY <input type="checkbox"/> CONSULTANT <input type="checkbox"/> COURTESY <input type="checkbox"/> LIMITED <input type="checkbox"/> PROVISIONAL <input type="checkbox"/> SENIOR ATTENDING <input type="checkbox"/> SURGICAL <input type="checkbox"/> SUSPENDED			
<input type="checkbox"/> EMAIL ATTESTATION ON FILE			
<b>ACTION REQUIRED (Check all that apply)</b>			
<input type="checkbox"/> <b>NEW ADD OR AFFILIATION</b>	<b>REQUIREMENTS:</b> The Provider Relations (PR) representative must complete this form, including <u>credentialing information</u> , for each provider being added as a provider affiliate. In addition, <u>a copy of the notification and signature pages from the provider contract and a W-9 form</u> 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.		
	<b>Effective Date (required):</b>	<b>Done Credentialing Completed (within the last three years)</b>	<b>Current Facility Site Review Date (within the last three years)</b>
<input type="checkbox"/> <b>CHANGE IN PANEL STATUS</b>	<b>PROVIDER TYPE</b>	<input type="checkbox"/> <b>ANCILLARY/ALLIED HEALTH</b> <input type="checkbox"/> <b>PCP</b> <input type="checkbox"/> <b>SPECIALIST</b> <input type="checkbox"/> <b>ECM</b> <input type="checkbox"/> <b>COMMUNITY SUPPORTS</b>	
	<b>PROVIDER TYPE (If applicable, check box)</b>	<input type="checkbox"/> <b>Open Panel</b> <input type="checkbox"/> <b>Closed Panel</b> <input type="checkbox"/> Accepting new patients <input type="checkbox"/> Accepting existing patients <input type="checkbox"/> Accepting new patients through referral <input type="checkbox"/> Accepting new patients through a hospital/facility <input type="checkbox"/> Not accepting new patients	
<input type="checkbox"/> <b>TAX ID CHANGE</b>	<b>REQUIREMENTS:</b> The health network must attach a copy of the provider notification indicating the change of tax ID AND a new W-9 form.		
	<b>Effective Date of New Tax ID (required)</b>	<b>Previous Tax ID</b>	<b>New Tax ID</b>

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## ADD, CHANGE AND TERMINATION (ACT) FORM



ACTION REQUIREMENTS (cont.) (Check all that apply)			
<input type="checkbox"/>	<b>TERMINATION</b>	<p><b>REQUIREMENTS:</b> Complete this form for each provider being terminated from its provider network affiliation. 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 POMG and returned to the PR representative.</p> <p>Effective date (required): _____ <input type="checkbox"/> PCP <input type="checkbox"/> SPECIALIST <input type="checkbox"/> ANCILLARY</p> <p>Date CalOptima Health received the termination notice: _____</p> <p>Exceptions: Review found that the terminated specialist is exempt from providing continued access based on the exemption checked below.</p> <div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> Provider not available  <input type="checkbox"/> Provider resigned  <input type="checkbox"/> Contract not continued  <input type="checkbox"/> Other: _____                 </div> <div> <input type="checkbox"/> Provider deceased  <input type="checkbox"/> Provider unwilling to accept member payment terms  <input type="checkbox"/> Termined due to review action                 </div> </div> <p>PCP Termination: Assign member to new PCP: _____                      Name of new PCP: _____</p> <p>Number of members impacted (as of date received): <input type="checkbox"/> Medi-Cal _____ <input type="checkbox"/> OneCare _____</p> <p>Date member notice was mailed (if member notice has not been sent, please put anticipated date and notify CalOptima Health if date changes): _____</p> <p>Number of days' notice provider gave to MCP: _____</p>	
<input type="checkbox"/>	<b>ADDRESS/PHONE CHANGE OR ADDITIONAL LOCATION</b>	<p><b>REQUIREMENTS:</b> 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 use, 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: This form contains three address sections, allowing multiple changes to be entered for one provider on this same form.</p> <div style="display: flex;"> <div style="flex: 1;"> <p><b>SERVICE ADDRESS</b> Check one: <input type="checkbox"/> [ADD] <input type="checkbox"/> [TERM]</p> <p>Effective Date (required): _____</p> <p>Address: _____ City: _____ State: _____ Zip: _____</p> <p>Phone: _____ Fax: _____ Office Hours: _____ After Hours Phone: _____</p> <p>Office Manager: _____ Email Address: _____</p> </div> <div style="flex: 1;"> <p><b>SITE TELEHEALTH INDICATORS</b>  <input type="checkbox"/> Telehealth Only <input type="checkbox"/> No Telehealth  <input type="checkbox"/> Both Telehealth and In-Person</p> </div> </div> <div style="display: flex;"> <div style="flex: 1;"> <p><b>SERVICE ADDRESS</b> Check one: <input type="checkbox"/> [ADD] <input type="checkbox"/> [TERM]</p> <p>Effective Date (required): _____</p> <p>Address: _____ City: _____ State: _____ Zip: _____</p> <p>Phone Number: _____ Fax Number: _____ Office Hours: _____ After Hours Phone Number: _____</p> <p>Office Manager: _____ Email Address: _____</p> </div> <div style="flex: 1;"> <p><b>SITE TELEHEALTH INDICATORS</b>  <input type="checkbox"/> Telehealth Only <input type="checkbox"/> No Telehealth  <input type="checkbox"/> Both Telehealth and In-person</p> </div> </div>	
<input type="checkbox"/>	<b>LANGUAGE</b>	<p>Languages Spoken by Staff</p> <p>1. _____ 2. _____ 3. _____</p> <p>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)</p> <p>1. _____ 2. _____ 3. _____</p> <p>4. _____ 5. _____ 6. _____</p> <p><u>Language services, such as American Sign Language (ASL), and interpreter services</u>                      (Check all that apply)</p> <p><input type="checkbox"/> In-office ASL interpreter <input type="checkbox"/> In-office medical interpreter  <input type="checkbox"/> Other type of in-office interpreter service, fill in here: _____</p>	
<input type="checkbox"/>	<b>Race/Ethnicity</b>	<p><sup>h</sup> Race/ethnicity of provider. Check all that apply:</p> <div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> American Indian Alaska Native  <input type="checkbox"/> Asian  <input type="checkbox"/> Black or African American  <input type="checkbox"/> Hispanic or Latino                 </div> <div> <input type="checkbox"/> Middle Eastern or North African  <input type="checkbox"/> Native Hawaiian or Pacific Islander  <input type="checkbox"/> White  <input type="checkbox"/> Choose not to share                 </div> </div>	
<input type="checkbox"/>	<b>OTHER</b>	<p>Comments:</p> <p>_____</p>	
<p><b>PROVIDER RELATIONS REPRESENTATIVE</b>                      (Please print)</p> <p>_____</p>			
<p><b>PROVIDER NAME</b>                      (Please print)</p> <p>_____</p>			
<p><b>SIGNATURE</b></p> <p>_____</p>		<p><b>DATE</b></p> <p>_____</p>	

<sup>h</sup>Optional to answer and not required

# CalOptima Health User Guide

## ADD, CHANGE AND TERMINATION (ACT) FORM



### Add, Change and Termination Form

**Sample  
Termination**

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.

<b>Health Network Name:</b>			
<b>Program (Check all that apply):</b> <input type="checkbox"/> Medi-Cal <input type="checkbox"/> OneCare <input type="checkbox"/> PACE			
<b>PROVIDER INFORMATION</b>			
<b>PROVIDER STATE LICENSE #</b>		<b>PROVIDER TIN #</b>	
<b>TYPE 1 NPI (National Provider ID #)</b>	<b>PROVIDER ID</b>	<b>MEDICARE #</b>	<b>MEDI-CAL EFFECTIVE DATE</b>
<b>PROVIDER NAME (Last)</b>		<b>First</b>	<b>Middle Initial</b>
<b>PRIMARY TAXONOMY</b>	<b>SECONDARY TAXONOMY</b>	<b>TERTIARY TAXONOMY</b>	<b>ORDERING, REFERRING, PRESCRIBING (ORP)</b> <input type="checkbox"/> YES <input type="checkbox"/> NO
<b>AREA OF FOCUS</b>	<b>PRIMARY SPECIALTY</b>	<b>SECONDARY SPECIALTY</b>	
<b>GROUP NAME</b>		<b>PROVIDER TELEHEALTH INDICATORS</b> <input type="checkbox"/> Telehealth Only <input type="checkbox"/> No Telehealth <input type="checkbox"/> Both Telehealth and in-person	
<b>GROUP TYPE 2 NPI (National Provider ID #)</b>	<b>GROUP ID</b>	<b>GROUP TIN</b>	
<b>SERVICE ADDRESS FOR AFFILIATION (See Page 2 for address changes and additional locations)</b>		<b>CITY</b>	<b>STATE</b> <b>ZIP</b>
<b>REMIT ADDRESS</b>		<b>CITY</b>	<b>STATE</b> <b>ZIP</b>
<b>OFFICE MANAGER</b>	<b>PHONE</b>	<b>FAX</b>	<b>PUBLIC EMAIL ADDRESS</b>
<b>ADMINISTRATION EMAIL ADDRESS</b>	<b>WEBSITE URL ADDRESS</b>	<b>SPECIAL SERVICES</b> <input type="checkbox"/> CCS <input type="checkbox"/> CRSP	
<b>HOSPITAL/FACILITY AFFILIATIONS AND ADMITTING PRIVILEGES</b>			
1. <input type="checkbox"/> NONE <input type="checkbox"/> ACTIVE <input type="checkbox"/> ASSOCIATE STAFF <input type="checkbox"/> HONORARY <input type="checkbox"/> CONSULTANT <input type="checkbox"/> COURTESY <input type="checkbox"/> LIMITED <input type="checkbox"/> PROVISIONAL <input type="checkbox"/> SENIOR ATTENDING <input type="checkbox"/> SURGICAL <input type="checkbox"/> SUSPENDED			
2. <input type="checkbox"/> NONE <input type="checkbox"/> ACTIVE <input type="checkbox"/> ASSOCIATE STAFF <input type="checkbox"/> HONORARY <input type="checkbox"/> CONSULTANT <input type="checkbox"/> COURTESY <input type="checkbox"/> LIMITED <input type="checkbox"/> PROVISIONAL <input type="checkbox"/> SENIOR ATTENDING <input type="checkbox"/> SURGICAL <input type="checkbox"/> SUSPENDED			
3. <input type="checkbox"/> NONE <input type="checkbox"/> ACTIVE <input type="checkbox"/> ASSOCIATE STAFF <input type="checkbox"/> HONORARY <input type="checkbox"/> CONSULTANT <input type="checkbox"/> COURTESY <input type="checkbox"/> LIMITED <input type="checkbox"/> PROVISIONAL <input type="checkbox"/> SENIOR ATTENDING <input type="checkbox"/> SURGICAL <input type="checkbox"/> SUSPENDED			
<input type="checkbox"/> EMAIL ATTESTATION ON FILE			
<b>ACTION REQUIRED (Check all that apply)</b>			
<input type="checkbox"/> <b>NEW ADD OR AFFILIATION</b>	<b>REQUIREMENTS:</b> The Provider Relations (PR) representative must complete this form, including credentialing information, for each provider being added as a provider affiliate. In addition, <u>a copy of the registration and signature pages from the provider contract and a W-9 form</u> 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.		
	<b>Effective Date (required):</b>	<b>Date Credentialing Completed (within the last three years)</b>	<b>Current Facility Site Review Date (within the last three years)</b>
<input type="checkbox"/> <b>PROVIDER TYPE</b>	<input type="checkbox"/> ANCILLARY/ALLIED HEALTH <input type="checkbox"/> PCP <input type="checkbox"/> SPECIALIST <input type="checkbox"/> ECM <input type="checkbox"/> COMMUNITY SUPPORTS		<input type="checkbox"/> Open Panel <input type="checkbox"/> Closed Panel <input type="checkbox"/> Accepting new patients <input type="checkbox"/> Accepting existing patients <input type="checkbox"/> Accepting new patients through referral <input type="checkbox"/> Accepting new patients through a hospital/affiliation <input type="checkbox"/> Not accepting new patients
<input type="checkbox"/> <b>CHANGE IN PANEL STATUS</b>	<b>REQUIREMENTS:</b> Panel changes are effective the date of processing.		
	<b>PROVIDER TYPE (If applicable, check both)</b>	<input type="checkbox"/> PCP <input type="checkbox"/> SPECIALIST <input type="checkbox"/> ECM <input type="checkbox"/> COMMUNITY SUPPORTS	<input type="checkbox"/> Open Panel <input type="checkbox"/> Closed Panel <input type="checkbox"/> Accepting new patients <input type="checkbox"/> Accepting existing patients <input type="checkbox"/> Accepting new patients through referral <input type="checkbox"/> Accepting new patients through a hospital/affiliation <input type="checkbox"/> Not accepting new patients
<input type="checkbox"/> <b>TAX ID CHANGE</b>	<b>REQUIREMENTS:</b> The health network must attach a copy of the provider notification indicating the change of tax ID AND a new W-9 form.		
	<b>Effective Date of New Tax ID (required):</b>	<b>Previous Tax ID</b>	<b>New Tax ID</b>



# CalOptima Health User Guide

## ADD, CHANGE AND TERMINATION (ACT) FORM



ACTION REQUIREMENTS (cont.) (Check all that apply)			
<input type="checkbox"/> <b>TERMINATION</b>	<b>REQUIREMENTS:</b> Complete this form for each provider being terminated from his provider network affiliation. 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 PD MG and returned to the PR representative.		
	Effective date (required):	<input type="checkbox"/> PCP <input type="checkbox"/> SPECIALIST <input type="checkbox"/> 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. <input type="checkbox"/> Provider not available <input type="checkbox"/> Provider retired <input type="checkbox"/> Contract not continued <input type="checkbox"/> Leave: _____ <input type="checkbox"/> Provider deceased <input type="checkbox"/> Provider unwilling to accept member payment terms <input type="checkbox"/> Termed due to review action		
	<b>PCP Termination:</b> Assign member to new PCP: _____ Name of new PCP		
	Number of members impacted (as of date received): <input type="checkbox"/> Medi-Cal _____ <input type="checkbox"/> 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:		
<input type="checkbox"/> <b>ADDRESS/PHONE CHANGE OR ADDITIONAL LOCATION</b>	<b>REQUIREMENTS:</b> 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: This form contains three address sections, allowing multiple changes to be entered for one provider on the same form.		
	<b>SERVICE ADDRESS</b> Check one: <input type="checkbox"/> ADD <input type="checkbox"/> TERM	Effective Date (required):	<b>SITE/TELEHEALTH INDICATORS</b> <input type="checkbox"/> Telehealth Only <input type="checkbox"/> No Telehealth <input type="checkbox"/> Both Telehealth and In-Person
	Address:	City:	State: ZIP:
	Phone:	Fax:	Office Hours: After Hours Phone:
	Office Manager:	Email Address:	
	<b>SERVICE ADDRESS</b> Check one: <input type="checkbox"/> ADD <input type="checkbox"/> TERM	Effective Date (required):	<b>SITE/TELEHEALTH INDICATORS</b> <input type="checkbox"/> Telehealth Only <input type="checkbox"/> No Telehealth <input type="checkbox"/> Both Telehealth and In-Person
	Address:	City:	State: ZIP:
	Phone Number:	Fax Number:	Office Hours: After Hours Phone Number:
	Office Manager:	Email Address:	
	<input type="checkbox"/> <b>LANGUAGE</b>	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. _____			
<input type="checkbox"/> <b>Race/Ethnicity</b>	Language services, such as American Sign Language (ASL), and interpreter services. Check all that apply: <input type="checkbox"/> In-office ASL interpreter <input type="checkbox"/> In-office medical interpreter <input type="checkbox"/> Other type of in-office interpreter service, fill in here: _____		
	* Race/Ethnicity of provider. Check all that apply: <input type="checkbox"/> American Indian Alaska Native <input type="checkbox"/> Middle Eastern or North African <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> Black or African American <input type="checkbox"/> White <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Choose not to share		
<input type="checkbox"/> <b>OTHER</b>	Comments:		
<b>PROVIDER RELATIONSHIP REPRESENTATIVE</b> (Please print)			
<b>PROVIDER NAME</b> (Please print)			
<b>SIGNATURE</b>		<b>DATE</b>	

### 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

11-1-18 ACT – PCP Term Monarch Moore, Hezekiah N MD (A12345) (Medi-Cal, OC)

Submission Date    Provider Type    Request Type    Health Network    Provider Last Name    Provider First Name    License #    Line of Business

##### Provider email subject header naming convention:

Submission Date: Date form is submitted

Provider Type: PCP, SPC, MIDDLELEVEL, 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

11-1-18 ACT – Demo Change CCN – Kindred Hospital Santa Ana (1234567891) (Medi-Cal, OC,)

Submission Date    Request Type    Health Network    Facility Name    Facility NPI    Line of Business

##### 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

11-1-18 ACT – Tax Change AltaMed – Fairview Medical Group (99-99999999)\_(1234567897) (Medi-Cal, OC)

Submission Date    Request Type    Health Network    Group Name    Tax ID#    NPI#    Line of Business

##### 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

# CalOptima Health User Guide

## 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.

# CalOptima Health User Guide

## ADD, CHANGE AND TERMINATION (ACT) FORM



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.
FAX NUMBER	Fax number at practice location. No space or special character and 10-digit number only.
PUBLIC EMAIL	Email address the practitioner would like to be published on the directory for inquiries from CalOptima Health members. Note: It is NOT site contact person's email.
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.

# CalOptima Health User Guide

## ADD, CHANGE AND TERMINATION (ACT) FORM



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 / FACILITY 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.
STAFF LANGUAGE	The language spoken by office staff (not providers) at practice location. Use Language tab.

CalOptima Health User Guide

ADD, CHANGE AND TERMINATION (ACT) FORM



PRACTITIONER LANGUAGE	The language practitioner speaks. 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