



OPTUM SAN DIEGO PUBLIC SECTOR PROVIDER UPDATE FORM

Dear Provider:

The purpose of this form is to request a change of name or address to your treatment location(s) as viewed on your provider profile and online provider directory, mailing address and/or billing address.

Please reference the following list of definitions as you complete this form.

TREATMENT LOCATIONS:

ACCEPTING NEW PATIENTS/CLIENTS:

MEDI-CAL:

- **Accepting New Clients:**

Access and Crisis Line can provide your contact information to callers who request a referral to a provider with your license type stating you are currently open to referrals for **outpatient** treatment.

- **Not Accepting New Clients:**

Your contact information will NOT be provided to callers who are requesting a referral to a provider with your license type. You may still choose to accept clients through other sources, however, you will show as “Not Accepting New Clients” in the Provider Directory and Access and Crisis Line Provider Database.

WAIT TIMES:

- **Urgent Appointments**

All services without prior approval

Wait Time

48 hours

- **Non-Urgent Appointment**

Specialist appointment (Physician)

Appointment with a mental health specialist (non-physician)

Wait Time

15 business days

10 business days

Please submit the completed Provider Update Form and supporting documents (if applicable) to:

Email: sdu_providerserviceshelp@optum.com

Fax: 877-309-4862

If you have any questions about completing this form, please contact Provider Services at 1-800-798-2254, option 7.

OPTUM SAN DIEGO PUBLIC SECTOR PROPLEASE

PLEASE EMAIL OR FAX TO:
sdu_providerserviceshelp@optum.com or Fax # 877-309-486

PROVIDER NAME: _____

DATE: _____

ADD PRIVATE PRACTICE (Must submit W-9 Form)

ADD GROUP PRACTICE (Must submit W-9 Form)

EFFECTIVE DATE: _____

Business Name: _____

Tax ID#: _____

NPI#: _____

NEW TAX I.D. NUMBER (Must submit W-9 Form)

EFFECTIVE DATE: _____

W-9 Form must be signed and dated.

If your Taxpayer Identification Number (TIN) is your social security number, please provide a **copy of your social security card.**

If your Taxpayer Identification Number (TIN) is an employer identification number (EIN), please provide a **copy of form SS-4** (IRS EIN assignment notification letter)

ADD NEW TREATMENT LOCATION

Business Name: _____

Address: _____

City/State/Zip: _____

Phone: _____, **Fax:** _____

EMAIL (Client Use):
(Secure-HIPAA compliant)

EMAIL (Business Use): _____

ACCEPTING NEW PATIENTS/CLIENTS:

MEDI-CAL:(including those from The San Diego Access and Crisis Line and the Provider Directory) [YES NO

TERM-CWS (If applicable) [YES NO

WAIT TIMES:

Urgent Appointments: _____ Hours

Non-Urgent Appointments: _____ Business Days

Does this office meet ADA* guidelines? [YES NO

*Americans with Disabilities Act

Is office accessible to public transportation? [YES NO

Home Office? [YES NO

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PLEASE EMAIL OR FAX TO:
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PROVIDER NAME: _____ DATE: _____

| | |
|--|---|
| ADD ADDITIONAL TREATMENT LOCATION <input type="checkbox"/> | |
| Business Name: | |
| Address: | |
| City/State/Zip: | |
| PHONE: _____ | , FAX: _____ |
| EMAIL (Client Use): <small>(Secure-HIPAA compliant)</small> | |
| EMAIL (Business Use): | |
| ACCEPTING NEW PATIENTS/CLIENTS: | |
| MEDI-CAL:(including those from The San Diego Access and Crisis Line and the Provider Directory) | [YES <input type="checkbox"/> NO <input type="checkbox"/> |
| TERM-CWS (If applicable) | [YES <input type="checkbox"/> NO <input type="checkbox"/> |
| WAIT TIMES: | |
| Urgent Appointments: _____ | Hours |
| Non-Urgent Appointments: _____ | Business Days |
| Does this office meet ADA* guidelines? <small>*Americans with Disabilities Act</small> | [YES <input type="checkbox"/> NO <input type="checkbox"/> |
| Is office accessible to public transportation? | [YES <input type="checkbox"/> NO <input type="checkbox"/> |
| Home Office? | [YES <input type="checkbox"/> NO <input type="checkbox"/> |

| | |
|---|--|
| ADD NEW MAILING ADDRESS <input type="checkbox"/> | |
| Business Name: | |
| Address: | |
| City/State/Zip: | |

| | | |
|--|--|-----------------------------|
| ADD NEW BILLING ADDRESS <input type="checkbox"/> (Must submit W-9 Form) | | EFFECTVE DATE: _____ |
| Business Name: | | |
| Address: | | |
| City/State/Zip: | | |
| PHONE: _____ | | , CONTACT: _____ |

**OPTUM SAN DIEGO PUBLIC SECTOR
PROVIDER UPDATE FORM**

**PLEASE EMAIL OR FAX TO:
sdu_providerserviceshelp@optum.com or Fax # 877-309-486**

PROVIDER NAME: _____ **DATE:** _____

| |
|---|
| REMOVE GROUP PRACTICE <input type="checkbox"/> |
| REMOVE PRIVATE PRACTICE <input type="checkbox"/> |
| EFFECTIVE DATE: _____ |

Business Name: _____

Treatment Location Address: _____

City/State/Zip: _____

PHONE: _____, **FAX:** _____, **CONTACT:** _____

GROUP Tax ID#: _____

GROUP NPI#: _____

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| <p>DO YOU CURRENTLY HAVE OPEN AUTHORIZATIONS THAT NEED TO BE MOVED TO YOUR NEW PRACTICE: Y/N</p> <p>*If Yes, please provide a list of clients.</p> |
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