



OPTUM SAN DIEGO PUBLIC SECTOR PROVIDER UPDATE FORM

Dear Provider:

The purpose of this form is to request a change of 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 PROVIDER UPDATE FORM

PLEASE EMAIL OR FAX TO:
sdu_providerserviceshelp@optum.com or Fax # 877-309-4862

PROVIDER NAME: _____

DATE: _____

ADD NEW PRIMARY TREATMENT LOCATION <input type="checkbox"/>	DELETE OLD PRIMARY TREATMENT LOCATION <input type="checkbox"/>
Business Name:	Business Name:
Address:	Address:
City/State/Zip:	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 <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? [YES <input type="checkbox"/> NO <input type="checkbox"/>	
<small>*Americans with Disabilities Act</small>	
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 ADDITIONAL TREATMENT LOCATION <input type="checkbox"/>	DELETE ADDITIONAL TREATMENT LOCATION <input type="checkbox"/>
Business Name:	Business Name:
Address:	Address:
City/State/Zip:	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 <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? [YES <input type="checkbox"/> NO <input type="checkbox"/>	
<small>*Americans with Disabilities Act</small>	
Is office accessible to public transportation? [YES <input type="checkbox"/> NO <input type="checkbox"/>	
Home Office? [YES <input type="checkbox"/> NO <input type="checkbox"/>	

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PLEASE MAIL OR FAX TO:
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PROVIDER NAME: _____

DATE: _____

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

ADD NEW BILLING ADDRESS <input type="checkbox"/>	DELETE OLD BILLING ADDRESS <input type="checkbox"/>
EFFECTIVE DATE: _____	
Business Name:	Business Name:
Address:	Address:
City/State/Zip:	City/State/Zip:
PHONE: _____, CONTACT: _____	

ADD PRIVATE PRACTICE <input type="checkbox"/> (Must submit W-9 Form with TIN Verification)
ADD GROUP PRACTICE <input type="checkbox"/> (Must submit W-9 Form with TIN Verification)
EFFECTIVE DATE: _____
Business Name:
Address:
City/State/Zip:
PHONE: _____, FAX: _____, CONTACT: _____
GROUP NPI#: _____
GROUP Tax ID#: _____ (Must submit W-9 Form and TIN Verification)
<input type="checkbox"/> W-9 Form must be signed and dated. <input type="checkbox"/> If your Taxpayer Identification Number (TIN) is your social security number, please provide a copy of your social security card . <input type="checkbox"/> 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)
DO YOU CURRENTLY HAVE OPEN AUTHORIZATIONS THAT NEED TO BE MOVED TO YOUR GROUP PRACTICE: Y/N
*If Yes, please provide a list of clients.

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

**PLEASE EMAIL OR FAX TO:
sdu_providerserviceshelp@optum.com or Fax # 877-309-4862**

PROVIDER NAME: _____

DATE: _____

CHANGE TAX I.D. NUMBER **(Must submit W-9 Form and TIN Verification)**

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)

REMOVE GROUP PRACTICE

REMOVE PRIVATE PRACTICE

EFFECTIVE DATE: _____

Business Name: _____

Treatment Location Address: _____

City/State/Zip: _____

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

GROUP Tax ID#: _____