RMHS
Rocky Mountain Human Services

Practitioner Change of Information Form

This form and all content will be used solely for RMHS internal business requirements.

Please select and complete the information which you are requesting be updated with the RMHS provider network and submit this form to;
Email to: Credentialing@rmhumanservices.org

*Please check applicable boxes for the information you wish to change

- ☐ Name
- ☐ Title/position
- ☐ Supervising practitioner
- ☐ License
- ☐ Service Delivery
- ☐ Specialties
- ☐ Contact information

1. Previous Name:_____ New Name: _____

   a. Please ensure that you have updated the following systems:

   - ☐ NPPES (NPI)
   - ☐ CO Medicaid
   - ☐ EI Colorado Provider Portal
   - ☐ Applicable licensing boards (ASHA, NBCOT, ABPTS, BCBA, etc)
   - ☐ DORA/CDE
   - ☐ Active out of state licenses
   - ☐ CAQH (If a Credentialed practitioner)

2. Practitioner Title:_____

3. Supervising Practitioner (please list if an Assistant, Aid or CF):_____

4. State License #:_____ Expiration Date: _____

5. Service Delivery (choose at least one):

   ☐ In-person in the child's natural setting ☐ Telehealth ☐ Both

6. Practitioner Specialties:

   - ☐ Augmentative and Alternative Communication (AAC)
   - ☐ Assistive Technology
   - ☐ Deaf / Hard of Hearing
   - ☐ Feeding / Oral Motor
   - ☐ Infants / Preemies
   - ☐ Mental Health / Trauma
   - ☐ Sensory Processing
   - ☐ Sleep
   - ☐ Other: _____

7. Contact Information:

   E-Mail Address:_____

   Cell Phone:_____ Office Phone:_____

   *Person Completing Form:_____

   Title:_____ Date Form Completed:_____