RMHS
Rocky Mountain Human Services

Practitioner Add/Exit Form

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

Please complete and submit this form to add or remove practitioners to the RMHS provider network; Email to: DBH@rmhumanservices.org

Instructions: Please complete items 1-19 for adding practitioners; only 20-23 is needed for practitioner resigning or being terminated.

1. Practitioner Legal Name:_____DOB: _____
2. Agency/Business Name: _____
3. Practitioner Title/Degree:_____ Practitioner SSN:_____
    a. Supervising Practitioner (please list if an Assistant, Aid or CF):_____
4. Is this practitioner an employee with the agency listed above? ☐ **YES** ☐ NO
5. **Practitioner Credentialing – If RMHS will be handling your billing for Denver Health as an opt-in Agency, the practitioner will be required to go through the formal credentialing process. RMHS requires the following practitioner types to complete credentialing prior to receiving referrals for clients with DH: PT, OT, SLP, BCBA, RBT, LCSW, LSW, LP, LPC and PhD**. RMHS uses CAQH ProView for credentialing; if the practitioner has not completed a CAQH profile, please complete at https://proview.caqh.org/Login/Index?ReturnUrl=%2f.
    a. Is the practitioners CAQH up to date? ☐ YES
6. Credentialed Practitioners Medicaid Participation: **All practitioners must be a Medicaid approved provider prior to receiving RMHS referrals.**
    a. Opt-in: Has the practitioner been approved by Medicaid? ☐ YES, #_____
    Or
    b. Opt-Out: Does the company bill under an agency Medicaid ID? ☐ YES, ID# _____
7. **Does the practitioner have an EI Provider Portal Account? ☐ YES** ☐ NO
8. Date of EICO Provider Training: _____; Is the certificate in the EI portal? ☐ YES
9. Date of EICO Telehealth Training: _____; Is the certificate in the EI portal? ☐ YES
10. Date of your DC: 0-5 Training _____; Is the certificate in the EI Portal? ☐ YES
11. Have you registered with RMHS as a CCB in the EI Portal? ☐ YES
12. State License #:_____ Expiration Date: _____
13. Practitioner NPI: _____CAQH#: _____

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14. Board Certification (if applicable): _____(ASHA, NBCOT, etc.)

    a. Certification #: _____ Expiration Date: _____

15. Languages spoken:_____

16. Service Delivery (choose at least one):

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

17. 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: _____

18. Contact Information:

E-Mail Address:_____

Cell Phone:_____Office Phone:_____

19. Person Completing Form:_____

Title:_____ Date Form Completed:_____

Provider Exit Form

Please complete this section only upon practitioner exit from the agency, please see RMHS EI Provider and Billing Manual for more instruction. Please *Email to:* DBH@rmhumanservices.org

20. Practitioners Name:_____

21. Agency/Business Name:_____

22. Exit Date:_____

23. Reason for Exit:_____