

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.cagh.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#: _____

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:

- | | |
|---|---|
| <input type="checkbox"/> Augmentative and Alternative Communication (AAC) | <input type="checkbox"/> Mental Health / Trauma |
| <input type="checkbox"/> Assistive Technology | <input type="checkbox"/> Sensory Processing |
| <input type="checkbox"/> Deaf / Hard of Hearing | <input type="checkbox"/> Sleep |
| <input type="checkbox"/> Feeding / Oral Motor | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Infants / Premies | |

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:* Credentialing@rmhumanservices.org

20. Practitioners Name: _____

21. Agency/Business Name: _____

22. Exit Date: _____

23. Reason for Exit: _____