PROVIDER REQUEST FOR ADDRESS CHANGE/UPDATE

To ensure timely processing of your address update, please answer the following questions. In addition, please complete the Address Update form on the second page.

1. What services will be offered at this proposed new address/location? ____
   ____
   ____

2. Are you currently contracted with Beacon Health Options (formerly Value Behavioral Health of PA) to provide the services listed above, for the county in which your proposed new address will be located?
   Yes No

3. Is the proposed new address/location geographically in the same county as the provider address/location that is being changed? Yes No

4. Is the proposed new address/location within ten (10) miles from the current location? Yes No

5. Is the proposed new address/location expected to receive referrals from the same sources?
   Yes No

6. Will the proposed new address/location serve essentially the same population as the current location? Yes No

7. Do you have a current PROMISe ID (Pennsylvania Medicaid Number) for this service location? If so, please list: ____. If you do NOT have a PROMISe ID Number for this service location please refer to a or b below:

   a. **Facilities (for In-Plan levels of care), MDs and PhDs** you must obtain a PROMISe ID Number through OMAP. This can be done either by paper at: http://www.dhs.pa.gov/provider/promise/enrollmentinformation/S_001994 or via their electronic portal at: https://provider.enrollment.dpw.state.pa.us/

   b. **Facilities (for Supplemental Services), and Licensed Masters Level Practitioners** you must obtain a PROMISe ID Number through OMHSAS with Beacon's assistance. Once you return this completed form, Beacon Health Options (formerly Value Behavioral Health of PA) will reach out to you to help you obtain one.

*__Please note: Obtaining a PROMISe ID number can be a lengthy process. Please allow sufficient time when planning to move.__

8. Please provide a current email address for correspondence: ______________________________

Please note that approval to add a new address/location for services is **dependent upon the status of the provider network for the applicable county(ies).** A list of currently open network services is available at Currently Open Network Services | Beacon Health Options of Pennsylvania

If you have any questions on how to complete the address update form, please contact your Provider Field Coordinator through our Service Center's toll-free Provider Line at 877-615-8503.

Beacon Health Options Address Update Form

Please list ALL current addresses in addition to any addresses we should delete from our files.

Facility Information:

Last Name First Name MI State License Type

All addresses listed below must correspond to the TIN listed in this section. **If you have more than one TIN, please photocopy this form at this point and complete a separate address change form for each Tax ID number you use.**

Tax ID# Tax ID Owner Name (must match W-9)

*****Note: If you have more than 2 Service Addresses for the above TIN, please photocopy the form at this point*****

DELETE this Service Address: (Referrals) Effective Date (*Required*) / /

Street Address/Suite

City State Zip

Phone ( )

Please list all services provided at this address

Is this a Primary Service Address? Yes No

Promise ID for this address: ___________________________

ADD/KEEP this Service Address: Effective Date (*Required*) / /

Street Address/Suite (No PO Boxes)

City State Zip

Phone ( )

Handicapped accessible? Y N Public Transportation accessible? Y N

Please list all services provided at this address:

Is this a Primary Service Address? Yes No

Promise ID for this address: ___________________________

DELETE this Mailing Address: (Certification Letters) Effective Date (*Required*) / /

Street Address/Suite/P O Box

City State Zip

Phone ( )

ADD/KEEP this Mailing Address: Effective Date (*Required*) / /

Street Address/Suite/PO Box

City State Zip

Phone ( )

DELETE this Billing (1099) Address: (Checks) Effective Date (*Required*) / /

Street Address/Suite/P O Box

City State Zip

Phone ( )

ADD/KEEP this Billing (1099) Address: Effective Date (*Required*) / /

Street Address/Suite/PO Box

City State Zip

Phone ( )

Provider Signature (Required):_ Date___________________

Please mail to: Beacon Health Options
Attention: Networks Dept.
P.O. Box 1840
Cranberry Twp., PA 16066-1840

OR

Fax to: 1-855-541-5211