If you are a contracted Health Share Pathways provider and are changing office locations, please complete this form and submit it to Health Share **at least 30 calendar days in advance of your office relocation**.

***\*Please type or print clearly\****

|  |  |
| --- | --- |
| **Provider Name:** | |
| **Date Form Completed:** |  |

**Previous Office Information**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Name of Office which is closing:** | | | | | | |
| **Address of Office which is closing:** | | | | | | |
| **Date Office is closing:** | | | | | | |
| **New Office Information** | | | | | | |
| **New Office Name:** | | | | | | |
| **New Street Address:** | | | | | | |
| **New City, State, Zip:** | | | | | | |
| **New Phone:** | | **New Fax:** | | | | |
| **What day is this new office opening?** | |  | | | | |
| **Will services rendered at this location be billed using the same NPI as your previous location?** | | | | Yes  No | | |
| **If billing with a different NPI, please supply it below:** | | | | |
| **NPI for New Office:** | | N/A | |
| **Is this location ADA Accessible?** Yes  No | | | | | | |
| **If this location is not ADA accessible, how do you accommodate clients who require ADA accommodation?** | | | | | | |

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| **What are the office hours for the new location** (Please include days and hours)? |

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| **Foreign languages in which full spectrum of services can be offered at new location (including ASL)?** |
| No Foreign Languages Spoken at Location |
| **Culturally Specific Focus at Location (if applicable)**  *Please check only culturally specific foci in which providers at this location have experience and training for treating members within their specialty***:**   |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | |  | African American |  | Asian American |  | Hispanic/Latino | |  | Native American /Alaskan Native |  | Hawaiian/  Pacific Islander |  | LBGTQ+ | |  | Other (please specify): | | | | | |

**On the next two pages, please indicate which services are offered at the new office location in accordance with your Health Share contract.**

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| **Type(s) of Mental Health Services Offered at Location which are represented in your Health Share Agreement as a Covered Services & Compensation Addendum:** |

**Mental Health Services**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Service Type** *(check all that apply)* | | **Age(s) Served\*** *(check all that apply)* | | | | | | | |
|  | ABA |  | Child |  | Youth |  |  |  |  |
|  | ACT |  |  |  |  |  | Adult |  | Older Adults |
|  | CBIT |  | Child |  | Youth |  |  |  |  |
|  | Crisis Stabilization |  | Child |  | Youth |  |  |  |  |
|  | DBT - Fidelity |  | Child |  | Youth |  | Adult |  | Older Adults |
|  | Eating Disorder-Partial Hospitalization |  | Child |  | Youth |  | Adult |  | Older Adults |
|  | Eating Disorder-Residential |  | Child |  | Youth |  | Adult |  | Older Adults |
|  | IDD Medication Management |  | Child |  | Youth |  | Adult |  | Older Adults |
|  | Inpatient Psychiatric Hospitalization |  | Child |  | Youth |  | Adult |  | Older Adults |
|  | Mental Health IOP/Partial Hospitalization |  |  |  |  |  | Adult |  | Older Adults |
|  | Mental Health Outpatient |  | Child |  | Youth |  | Adult |  | Older Adults |
|  | Mental Health Outpatient: SPMI |  |  |  |  |  | Adult |  | Older Adults |
|  | Medication Management |  | Child |  | Youth |  | Adult |  | Older Adults |
|  | Psychiatric Day Treatment Services |  | Child |  | Youth |  |  |  |  |
|  | Psychological Testing |  | Child |  | Youth |  | Adult |  | Older Adults |
|  | Respite Services |  | Child |  | Youth |  |  |  |  |
|  | Sub-Acute Services |  | Child |  | Youth |  |  |  |  |
| **\*Child**: Ages 0-5 | **Youth**: Ages 6-17 | **Adult**: Ages 18-64 | **Older Adult**: Ages 65 and up | | | | | | | | | |

|  |  |
| --- | --- |
|  | No Mental Health services offered at this location |

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| **Type(s) of Substance Use Disorder Services Offered at Location which are represented in your Health Share Agreement as a Covered Services & Compensation Addendum:** | |
| **Substance Use Disorder Services** | |
| **Service Type** *(check all that apply)* | **Age(s) Served\*** *(check all that apply)* |

|  |  |  |  |  |  |  |  |  |  |
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|  | SUD Dual Diagnosis Residential  (Level 3.5) |  | Child |  | Youth |  | Adult |  | Older Adults |
|  | SUD High Intensity Medically-Monitored Residential Treatment Services (Level 3.7) |  |  |  |  |  | Adult |  | Older Adults |
|  | SUD Medication Assisted Treatment  (Opioid Treatment Program) |  |  |  |  |  | Adult |  | Older Adults |
|  | SUD Medication Assisted Treatment  (Office Based Opioid Treatment) |  |  |  |  |  | Adult |  | Older Adults |
|  | SUD Outpatient (Levels 1 and 2.1) |  | Child |  | Youth |  | Adult |  | Older Adults |
|  | SUD Partial Hospitalization/Day Treatment (Level 2.5) |  | Child |  | Youth |  | Adult |  | Older Adults |
|  | SUD Residential Treatment |  | Child |  | Youth |  | Adult |  | Older Adults |
|  | SUD Withdrawal Management / Detox (Level 3.7-WM) |  | Child |  | Youth |  | Adult |  | Older Adults |

**\*Child**: Ages 0-5 | **Youth**: Ages 6-17 | **Adult**: Ages 18-64 | **Older Adult**: Ages 65 and up

|  |  |
| --- | --- |
|  | No Substance Use Disorder services offered at this location |

If any of your administrative offices change changed (billing, mailing, etc), please complete and submit the Pathways Provider Administrative Address Update Form as well.

If the address on your W9 has changed, please include an updated current W9 along with this notice.

If you have questions about this form or your existing contract with Health Share, please contact our Contracting and Provider Network Development Department at 971-334-8056 or [providers@healthshareoregon.org](mailto:providers@healthshareoregon.org).

Please submit all pages of the completed form and pertinent supporting documents to [providers@healthshareoregon.org](mailto:providers@healthshareoregon.org) at least **30 calendar days in advance of your office relocation**.