Facility/Agency Change Form

- ✓ Submit a Facility/Agency Change Form (FCF) per TIN. Do not submit changes for multiple TINs on FCF.
- ✓ The preferred method for completing the FCF is electronically. Hand written changes may result in delayed or inaccurate processing.
- ✓ Return FCF to www.mhswi.com/providers/resources/behavioral-health-provider-demographic-updates.html

What change do you need to make?	Steps to Complete:
☐ Change/delete an address, email, telephone, and/or fax number	✓ Complete SECTION A ✓ Complete SECTION B ✓ Fill out ATTACHMENT F
☐ Change of billing address, telephone, and or fax number	✓ Complete SECTION A ✓ Complete SECTION D ✓ Attach an updated W-9 if the address is filed with the IRS on your 1099.
☐ Change of mailing address, telephone, and or fax number	✓ Complete SECTION A ✓ Complete SECTION B (Ia. and Ic. only)
☐ Adding a location under an NPI currently credentialed with MHS Health Wisconsin	✓ Complete SECTION A ✓ Complete SECTION B ✓ Complete SECTION C ✓ Fill out ATTACHMENT F
☐ Adding a location for a new NPI that is *not* currently credentialed with MHS Health Wisconsin	✓ Submit a Join-Out-Network request www.mhswi.com/providers/become-a-provider/join-our-network
☐ Change Taxonomy	✓ Complete SECTION A ✓ Complete SECTION E
☐ Discontinue Behavioral Health Services ☐ Adding/changing TIN or changing ownership ☐ Adding a Level of Care	✓ Contact your Provider Relations Rep *Visit www.mhswi.com/providers to locate your Rep's contact information*

SECTION A REQUIRED INFORMATION

Today's Date	**Effective Date of Change**	
Facility/Agency Name as it appears on W9	**Type of Facility/Agency**	
Medicaid Number	**Medicare Number**	**Phone**
Facility/Agency NPI	**TIN**	**Taxonomy**
Main Contact Name	**Main Contact Email**	
Credentialing Contact Name	**Credentialing Contact Email**	

SECTION B CHANGE IN LOCATION INFO

☐	Delete location	Complete Ia and Ib
☐	Update Current Location	Complete Ia, and Ic, and complete II and III as applicable
☐	Add location	Complete Ic, II and III

Ia. Previous/Discontinued Practice Location

Facility/Agency Display Name			**Facility Type**
NPI	**Medicaid #**	**Taxonomy**	**Total IP Beds**
Address		**City** / **ST**	**Zip**
Contact Person			**Phone**
Contact Email			**Fax**

Ib. Provider your reason for deleting this location

NOTE: Must be a street address (not a PO Box)

Ic. Updated/New Practice Location

This is location # ☐ **DO NOT** Display in Directory ☐ This location is the Mailing Address

Facility/Agency Display Name			**Facility Type**
NPI	**Medicaid #**	**Taxonomy**	**Total IP Beds**
Address		**City** / **ST**	**Zip**
Contact Person			**Phone**
Contact Email			**Fax**

If the Updated/New location above is also the Billing address please also fill out SECTION D

II. Levels of Care offered at this location

Age Category	Mental Health						Substance Abuse						
	Inpatient	Partial	IOP	Residential	Observation	Other:___	I/P Detox	I/P Rehab	Partial	IOP	Residential	Ambulatory Detox	Other:___
Child													
Adol													
Adult													
Geri													
	ECT		I/P		O/P			Methadone			Suboxone		

III. Accessibility and Demographic Information

Is this location handicap accessible? ☐ Yes ☐ No		Are there gender limitations? ☐ M ☐ F	
Age limitations: _____ to _____		☐ All ages are accepted at this location	
Please list up to two languages other than English provided at this location: 1. _____ 2. _____			
Is this location currently accepting new patients? ☐ Yes ☐ No			
Office Hours: ☐ Open 24 hours		☐ By appt. only	

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
_____ to _____	_____ to _____	_____ to _____	_____ to _____	_____ to _____	_____ to _____	_____ to _____

SECTION C ACCREDITATION AND LICENSE/CERTIFICATION

☐ I have Accreditation certificates to attach ☐ I have a copy of my license to attach ☐ I have a site visit or survey to attach

Agency Name	Acronym	Issue Date	Expiration Date
Accreditation Commission for Health Care, Inc.	ACHC		
American Association of Ambulatory Health Centers	AAAHC		
American Osteopathic Hospital Association	AOHA		
Commission on Accreditation for Rehab Facilities	CARF		
Community Health Accreditation Program	CHAP		
Healthcare Quality Association on Accreditation	HQAA		
Joint Commission on Accreditation of Healthcare Organizations	JCAHO		
National Committee for Quality Assurance	NCQA		
Utilization Review Accreditation Commission/ Accreditation HealthCare Commission, Inc.	URAC		
State Facility Operating License	N/A		
Others (please list):			

	Issuing Entity	Type of Lic. or Cert.	License Number	Expiration Date
1.				
2.				
3.				

SECTION D CHANGE IN BILLING ADDRESS OR BILLING INFO

☐ Please update my 1099 Address *(a new W-9 is required)*

Facility/Agency Name as it appears on W9	**TIN**	**Medicaid Number**
New Billing Address		**NPI**
Phone	**Fax**	
Contact Person	**Contact Email**	

SECTION E CHANGE IN TAXONOMY

NPI associated with Taxonomy Change	
Current Taxonomy	**Current Taxonomy Description**
New Taxonomy	**New Taxonomy Description**

Signature

Date

Name

Title

Submit your FCF by uploading to
www.mhswi.com/providers/resources/behavioral-health-provider-demographic-updates.html.

Be sure to include your additional attachments if applicable.

Feel free to use the space below if you would like to further describe the changes that you are needing to make:

ROSTER OF AFFECTED PRACTITIONERS

ATTACHMENT F

☐ Changes affect all practitioners

☐ Changes affect only the practitioners listed below

First Name	Last Name	NPI	Section/s of FCF changes that are applicable