

Agency Update Form

**Please complete the entire form with all updates/changes to your agency’s information**

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| --- | --- |
| **Effective Date** | Click or tap here to enter text. |

|  |  |
| --- | --- |
|  | **ORIGINAL AGENCY** **INFORMATION** |
| **Agency DBA Name:** | Click or tap here to enter text. |
| **Legal Name:** | Click or tap here to enter text. |
| **Main** **Address:** | Click or tap here to enter text. |
| **Main** **Phone:** | Click or tap here to enter text. |
| **Main** **Fax:** | Click or tap here to enter text. |
|  | **NEW AGENCY** **CHANGE** **INFORMATION** |
| **Requesting** **Complete** **Name** **Change** **or** **DBA** **(Please** **Indicate):** | Click or tap here to enter text. |
| **Requesting** **Address/** **Phone/Fax** **Changed** **to:** | Click or tap here to enter text. |
| **Ownership** **Changes** **and**  ***Effective Date* of** **Change** | Click or tap here to enter text. |
|  | **Attach an Updated Form W-9 for any Legal or DBA Name changes, Remittance Address changes or changes to TIN** |
|  | **AGENCY** **VERIFICATION** **OF** **INFORMATION** |
| **Agency** **County** **Coverage:** | Click or tap here to enter text. |
| **Please list other Locations: (Include Full Address, Phone and Fax)** | Click or tap here to enter text. |
| **Does your agency have centralized Intake/Authorization and Billing? If so, which location?** | Click or tap here to enter text. |
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|  | **CLAIMS** **AND** **PAYMENT** **INFORMATION** |
| **The name and address you want CSI to submit your payments to:** | Click or tap here to enter text. |
| **The agency name/s that will appear on the claims that are submitted to CSI:** | Click or tap here to enter text. |

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|  | **Agency information pertinent to contracting and billing:** | |
| **Identification Numbers:** | **Changes?** | **If Identifiers changed, please add new identification numbers below:** |
| **Tax ID** | Yes No | Click or tap here to enter text. |
| **NPI Number** | Yes No | Click or tap here to enter text. |
| **Medicare** | Yes No | Click or tap here to enter text. |
| **Medicaid** | Yes No | Click or tap here to enter text. |

**We are committed to providing timely updates on changes from payers and to our processes. Please**

**designate *at least two primary contacts* within your agency who should receive these notifications:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **MAIN** **CONTACTS** **FOR** **AGENCY** | | | |
| **POSITION** | **NAME** | **PHONE** | **EMAIL ADDRESS** | **LOCATION** |
| **DON** | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
| **ADMIN** | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
| **INTAKE** | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
| **AUTHORIZATION** | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
| **BILLING** | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
| **OTHER** | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |

**Form Completed by**: (Agency Representative):

|  |  |
| --- | --- |
| **Name (please print)** | Click or tap here to enter text. |
| **Title** | Click or tap here to enter text. |
| **Signature** | Click or tap here to enter text. |
| **Date** | Click or tap here to enter text. |

**Please return this form via email to** [**joanne.kaminski@optioncare.com**](mailto:joanne.kaminski@optioncare.com) **or via mail to:**

CSI Network Services

Attention: Joanne Kaminski

6288 Hudson Crossing Parkway, Hudson, OH 44236

**Type of Changes** (in addition to this form - each requires the following):

**Address Change**

* Form W-9 (IRS’ most recent version, 03-2024)
* **COI** (**C**hange **o**f **I**nformation) letter from CMS and/or your MAC (*i.e*. Palmetto GBA, NGS, Noridian) approving the name change

**Legal and/or DBA Name**:

* Form W-9 (IRS’ most recent version, 03-2024)
* **COI** (**C**hange **o**f **I**nformation) letter from CMS and/or your MAC (*i.e*. Palmetto GBA, NGS, Noridian) approving the name change

**CHOW** (**C**hange **o**f **Ow**nership):

* Form W-9 (IRS’ most recent version, 03-2024)
* Disclosure of Ownership
* CHOW/Tie-In Notice from CSM and/or your MAC (i*.e.* Palmetto GBA, NGS, Noridian)

Questions - call 440-717-1700, Option #6 (Toll free 888-873-8999)

**check out our website:** [**https://optioncarehealth.com/csi**](https://optioncarehealth.com/csi)

**for the latest updates**

Internal Use Only

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| --- | --- |
| **SF Updated** | Click or tap here to enter text. |
| **AP notified** | Click or tap here to enter text. |
| **CPK Notified** | Click or tap here to enter text. |
| **Agency Roster** | Click or tap here to enter text. |