

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:
<input type="checkbox"/> Change/delete an address, email, telephone, and/or fax number	<ul style="list-style-type: none"> ✓ Complete SECTION A ✓ Complete SECTION B ✓ Fill out ATTACHMENT F
<input type="checkbox"/> Change of billing address, telephone, and or fax number	<ul style="list-style-type: none"> ✓ Complete SECTION A ✓ Complete SECTION D ✓ Attach an updated W-9 if the address is filed with the IRS on your 1099.
<input type="checkbox"/> Change of mailing address, telephone, and or fax number	<ul style="list-style-type: none"> ✓ Complete SECTION A ✓ Complete SECTION B (Ia. and Ic. only)
<input type="checkbox"/> Adding a location under an NPI currently credentialed with MHS Health Wisconsin	<ul style="list-style-type: none"> ✓ Complete SECTION A ✓ Complete SECTION B ✓ Complete SECTION C ✓ Fill out ATTACHMENT F
<input type="checkbox"/> Adding a location for a new NPI that is <i>not</i> currently credentialed with MHS Health Wisconsin	<ul style="list-style-type: none"> ✓ Submit a Join-Out-Network request www.mhswi.com/providers/become-a-provider/join-our-network
<input type="checkbox"/> Change Taxonomy	<ul style="list-style-type: none"> ✓ Complete SECTION A ✓ Complete SECTION E
<input type="checkbox"/> Discontinue Behavioral Health Services	<ul style="list-style-type: none"> ✓ Contact your Provider Relations Rep Visit www.mhswi.com/providers to locate your Rep's contact information
<input type="checkbox"/> Adding/changing TIN or changing ownership	
<input type="checkbox"/> Adding a Level of Care	

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

<input type="checkbox"/>	Delete location	Complete Ia and Ib
<input type="checkbox"/>	Update Current Location	Complete Ia, and Ic, and complete II and III as applicable
<input type="checkbox"/>	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

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

Ic. Updated/New Practice Location

This is location #	<input type="checkbox"/>	DO NOT Display in Directory	<input type="checkbox"/>	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? <input type="checkbox"/> Yes <input type="checkbox"/> No		Are there gender limitations? <input type="checkbox"/> M <input type="checkbox"/> F	
Age limitations: <input type="text"/> to <input type="text"/>		<input type="checkbox"/> All ages are accepted at this location	
Please list up to two languages other than English provided at this location: 1. <input type="text"/> 2. <input type="text"/>			
Is this location currently accepting new patients? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Office Hours: <input type="checkbox"/> Open 24 hours		<input type="checkbox"/> By appt. only	
Monday	Tuesday	Wednesday	Thursday
_____ to _____	_____ to _____	_____ to _____	_____ to _____
Friday	Saturday	Sunday	
_____ 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

<input type="checkbox"/> Please update my 1099 Address <i>(a new W-9 is required)</i>			
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:

