



Maricopa County Regional Behavioral Health Authority (RBHA)

Provider Staff Add/Change/Delete Form

Fax completed form to 888-656-6349

Use this form to notify Magellan Health Services of Arizona, the Maricopa County RBHA, of any changes to your Provider Agency Staff

Provider Agency Name: []

Provider Agency TIN: [] Provider Agency MIS #: []

Reason: [] Add Staff Member [] Change Staff Member Information [] Remove Staff Member

Staff Member Information

Last Name: [] First Name/Middle Initial: [] Provider MIS# (if known): []

Date of Birth: [] Credentials (if applicable): []

DEA # (if applicable): [] Job Title: []

NPI: [] Staff Member AHCCCS ID (if applicable): []

Staff Member Type (check all that apply):

- [] Licensed Professional License #: [] [] Psychiatrist
[] Psychologist [] Nurse Practitioner
[] Physicians Assistant [] Other []

Service Address: [] Hours Per Week at Location: []

City/State/ZIP: [] Phone: [] Site MIS# []

Participation:

- [] Add this Staff Member to this Location [] Remove this Staff Member from this Location
Effective Date: []

Service Address: [] Hours Per Week at Location: []

City/State/ZIP: [] Phone: [] Site MIS#: []

Participation:

- [] Add this Staff Member to this Location [] Remove this Staff Member from this Location
Effective Date: []

Service Address: [] Hours Per Week at Location: []

City/State/ZIP: [] Phone: [] Site MIS#: []

Participation:

- [] Add this Staff Member to this Location [] Remove this Staff Member from this Location
Effective Date: []

Effective date of the credentialing (affiliation to the site) will be the date the Credentialing Department receives a completed Staff Add/Change/Delete form and Group Association form.

For Magellan Use Only Date received by Magellan Credentialing Specialist: []
Date processed by Magellan Credentialing Specialist: []



Maricopa County Regional Behavioral Health Authority (RBHA)

Provider Staff Add/Change/Delete Form

Fax completed form to 888-656-6349

For New Magellan Providers Only: Professional History/Additional Liability Questions Please answer the following questions. Change Forms received without explanations for adverse responses will be returned to you as an "incomplete" and will not be processed.

A. Have you ever been named in any malpractice action? Yes No [checkbox] [checkbox]

If the answer to the above question is yes, please attach the following information for each suit or settlement whether open or closed, and regardless of whether or not payment was made:

- 1. A complete copy of the complaint filed stating the allegations and the current status.
2. If the actions have been settled or dismissed, a copy of the settlement or dismissal. If actions were settled, a statement explaining which party accepted liability for the action(s).
3. A claims history report from the insurer covering the claim.

B. Has there ever been any action against, investigation relating to, or disciplinary activity relating to your: Yes No

- 1. License (if applicable)
2. Medical Board or Professional Certification
3. DEA or Controlled Dangerous Substances Registration (if applicable)
4. Privileges in any facility or organization with which you had privileges

C. Have you ever been convicted of, pled guilty to, or pled nolo contendere, to any felony; misdemeanor (excluding minor traffic violations), or been found liable or responsible for any civil offense that is reasonably related to your qualifications, competence, functions, or duties as a professional, or for fraud, an act of violence, child abuse or a sexual offense or sexual misconduct?

D. Have you ever had any sanctions or other adverse actions filed against you by Medicare or Medicaid or any other Federal or State agency programs?

E. Have you ever been sanctioned by a professional association for ethical violations?

F. Are you presently using illegal drugs?

If the answer to any question above is yes, please explain (attach additional sheets as necessary):

Question [checkbox] : [text box]
[text box]

G. Are you able to perform the essential functions of a Magellan provider, including, but not limited to, treating members in a timely manner, complying with Magellan policies and procedures, rendering quality care to members, with or without accommodation?

If the answer to this question is no, please explain what accommodations are necessary for you to perform the essential functions of a provider:

[Large empty text box for explanation]

I hereby certify that all responses on this form are true and complete. I further understand that any information entered into this form that subsequently is found to be false could result in termination of my participation with the Magellan organization.

Signature: [text box] Date: [text box]
Signature of New Staff Person

Printed Name: [text box]