

# Agency/community mental health center/clinic clinician roster update form

Throughout this document, the term “agency” is used to refer to agencies, community mental health centers and clinics.



To help ensure proper maintenance of your independently licensed clinician roster, please complete and submit this form as staffing changes occur. You can also use this form to confirm that no changes to the roster are required at this time. Non-licensed staff should not be included on this report. Only include independently licensed staff who will submit claims. Please complete this form electronically rather than in handwriting, if possible. Multiple forms can be submitted if necessary.

**Email completed form to [cred\\_comm@uhc.com](mailto:cred_comm@uhc.com)**

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## Section A: Agency information/update type

Name of agency: \_\_\_\_\_

Update type:  Add, delete or update clinician data     Confirm that **no changes** are required to clinician data

Tax ID number (TIN): \_\_\_\_\_

All changes listed on this form must correspond to the TIN shown above. If the agency has more than one TIN, please submit a separate form for each TIN.

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## Section B: Deletions (List all independently licensed clinicians who have left the agency)

Last name	First name	Individual NPI	Effective date of deletion

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## Section C: Additions/updates

Check here if adding new clinician(s) or if existing clinician data requires updating. Complete a copy of page 2 for each clinician being added or updated.

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## Section D: Acknowledgement by administrator/roster contact

\_\_\_\_\_  
Roster contact (printed name)

\_\_\_\_\_  
Signature (or email address)

\_\_\_\_\_  
Date

**Section C (continued):** Complete one page for each new or updated independently licensed clinician

Add new clinician

Effective date of addition: \_\_\_\_\_

Update existing clinician data

Effective date of change: \_\_\_\_\_

Last name: \_\_\_\_\_

Individual NPI number: \_\_\_\_\_

First name: \_\_\_\_\_

Taxonomy: \_\_\_\_\_

Middle initial: \_\_\_\_\_

Social Security number: \_\_\_\_\_

License level (MD, LP, LCSW, APRN, etc.): \_\_\_\_\_

Date of birth: \_\_\_\_\_

License number: \_\_\_\_\_

Individual Medicare ID: \_\_\_\_\_

Prescriptive authority?  Yes  No

Medicare issue date: \_\_\_\_\_

Gender:  Male  Female

Individual Medicare ID: \_\_\_\_\_

Medicare issue date: \_\_\_\_\_

**Primary practice location** (cannot contain a P.O. Box):

Primary practice address	City	State	ZIP	Site conditions	Availability
				<input type="checkbox"/> Evening appts <input type="checkbox"/> Weekend appts <input type="checkbox"/> Public trans access <input type="checkbox"/> Wheelchair access	<input type="checkbox"/> Inpatient or in-home <input type="checkbox"/> Only accepting new patients
<b>Phone</b>	<b>Secure fax</b>	<input type="checkbox"/> No secure fax			

**Additional practice location(s)** (cannot contain a P.O. Box):

Add	Delete	Practice address	City	State	ZIP	Site conditions	Availability
<input type="checkbox"/>	<input type="checkbox"/>					<input type="checkbox"/> Evening appts <input type="checkbox"/> Weekend appts <input type="checkbox"/> Public trans access <input type="checkbox"/> Wheelchair access	<input type="checkbox"/> Inpatient or in-home <input type="checkbox"/> Only accepting new patients
		<b>Phone</b>	<b>Secure fax</b>	<input type="checkbox"/> No secure fax			

Add	Delete	Practice address	City	State	ZIP	Site conditions	Availability
<input type="checkbox"/>	<input type="checkbox"/>					<input type="checkbox"/> Evening appts <input type="checkbox"/> Weekend appts <input type="checkbox"/> Public trans access <input type="checkbox"/> Wheelchair access	<input type="checkbox"/> Inpatient or in-home <input type="checkbox"/> Only accepting new patients
		<b>Phone</b>	<b>Secure fax</b>	<input type="checkbox"/> No secure fax			

Add	Delete	Practice address	City	State	ZIP	Site conditions	Availability
<input type="checkbox"/>	<input type="checkbox"/>					<input type="checkbox"/> Evening appts <input type="checkbox"/> Weekend appts <input type="checkbox"/> Public trans access <input type="checkbox"/> Wheelchair access	<input type="checkbox"/> Inpatient or in-home <input type="checkbox"/> Only accepting new patients
		<b>Phone</b>	<b>Secure fax</b>	<input type="checkbox"/> No secure fax			