**School-Based Health Care Services**

**Annual Provider and Contact Update Form**

**Directions:** Complete page 1 to include information for all new and returning qualified health care providers who will be providing SBHS services. Also provide information for providers who have resigned within the last year. Submit this form to the Health Care Authority **annually** (by October 31st) and when changes in health care providers occur. **Email or fax** this form to the SBHS Program Specialist via email at shanna.muirhead@hca.wa.gov or fax to 360-725-1152.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| School district name      | Phone      | Fax      |  |  |
| Mailing address      | City      | ZIP code      |  |  |
| Verified and signed by director or designee      | Title      | Date      | School Year      |  |
| **Service Provider Name** | **Service Specialty** | **License orCertification Number** | **NPI Number** | **Last Issue Date** | **Expiration Date** | **Start Datewith District** | **Resignation Date** (if applicable) | **Subcontractor**(Y/N) | **Supervisor’s Name and Title**(if applicable) |
| Example: *Smith, John A.* | *Physical Therapist* | *PT-123456-L* | *123456789* | *00/00/0000* | *00/00/0000* | *00/00/0000* | *00/00/0000* | *N* | *Jane Doe, Ph.D., PT* |
|       |       |       |       |       |       |       |       |       |       |
|       |       |       |       |       |       |       |       |       |       |
|       |       |       |       |       |       |       |       |       |       |
|       |       |       |       |       |       |       |       |       |       |
|       |       |       |       |       |       |       |       |       |       |
|       |       |       |       |       |       |       |       |       |       |
|       |       |       |       |       |       |       |       |       |       |
|       |       |       |       |       |       |       |       |       |       |

**Copies of licenses, transcripts and NPI#s do not need to be sent with this form.**

**School-Based Health Care Services**

**Annual Provider and Contact Update Form**

**Directions:** Complete page 2 to include all current school district personnel contact information. This information must be completed annually (by October 31st) and when changes occur. This form is necessary to ensure that SBHS program information, contracts, and invoices are forwarded to the correct contact.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | **Name** | **Title** | **Mailing address** (if different from above) | **Phone** | **Fax** | **Email** |
| **Local Matching Funds Coordinator** |       |       |       |       |       |       |
| **Contract Coordinator with Signature Rights** |       |       |       |       |       |       |
| **Contract Coordinator with Receiving Rights** |       |       |       |       |       |       |
| **Provider and Contact Update Form** (12-325) **Coordinator** |       |       |       |       |       |       |
| **Medicaid Reimbursement Coordinator** (person who submits claims to Medicaid if self-biller) |       |       |       |       |       |       |
| **Superintendent** |       |  |       |       |       |       |
| **Special Education Director** |       |  |       |       |       |       |
| **Billing Agent** (if applicable) |       |  |  |  |  |  |