



# Behavioral Health Update Provider Information Form

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Director

PROVIDER NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

*(Individual name and Business/Corporate name)*

This is to notify the San Bernardino County Department of Behavioral Health that I have:

- Moved to a new office (complete #1 and #2)
- Added a new service location (complete #1)
- Changed Contact information, i.e., phone number/fax number/contact person (complete #3)
- 4) Closing service site location (complete #4):

1) The new address is:

\_\_\_\_\_ Phone Number: \_\_\_\_\_  
 \_\_\_\_\_ Fax Number: \_\_\_\_\_  
 \_\_\_\_\_ E-Mail Address: \_\_\_\_\_

This address is **effective** as of *(specify date)*: \_\_\_\_\_

- **Fee for Service Site Certification Form** must be submitted for each new location (form may be obtained by contacting Access Unit Provider Relations Representative).

This address replaces the current addresses I have on file for: *(check all that apply)*

- Mailing
- Billing
- Tax *(new W-9 form must be submitted)*
- No change of address(s) on file

2) The previous service site address to be taken off your profile (if applicable): **Inactive Date:** \_\_\_\_\_

3) Change of Contact Information:

Old Telephone number: \_\_\_\_\_ New Telephone number: \_\_\_\_\_

Old Fax number: \_\_\_\_\_ New Fax number: \_\_\_\_\_

Old Contact Person: \_\_\_\_\_ New Contact Person: \_\_\_\_\_

This change is **effective** as of *(specify date)*: \_\_\_\_\_

4) **Address of Service Site location to be closed:** **Effective Date:** \_\_\_\_\_

**Requirement to send a copy of:**

Notification to Access Unit with eff. date (30 days in advance)

Notification that was sent to clients

Other changes: \_\_\_\_\_

Provider Signature **(Required)**

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