South Country HEALTH ALLIANCE	**Contracted Entity Location Add/Remove Form**		SCHA # 5079 v5 (12/2023)
	Submit Fax Request to: 507-444-7774 Or Email to: providerinfo@mnscha.org	Or Mail to: South Country Health Alliance Attn: Contracting 6380 Frontage Rd W. Medford, MN 55049	SCHA Provider Network 866-722-7770

LOCATION ADDITIONS/REMOVALS MUST BE SUBMITTED <u>WITHIN 30 DAYS PRIOR TO THE EFFECTIVE DATE</u>.
Incomplete Facility Change/Update Form or missing W-9 Form will delay the change process.
Please submit a W-9 with this completed form.

Location Information

Type of Request:	☐ **Add Location** ☐ **Remove Location**			
Location Name:				
Requested Effective Date:				
Location Address:				
	City:	**State:**	**Zip:**	**County:**
Location NPI:				
Location Phone:		**Location Fax:**		
Contracting Contact Name:				
Contracting Contact Phone:				
Specialties:				
Location Type:	☐ Primary Care ☐ Specialty Care ☐ Mental Health ☐ Other			
Hospital Affiliations (if any)				
Practitioners:	Please list practitioners on Page 2 of this form.			
Directory Suppressed:	☐ Yes ☐ No			

Mailing Information

Mailing Address:		**City:**	**State:**	**Zip:**

Billing Information

Billing Address:		**City:**	**State:**	**Zip:**
Billing Phone:				
Tax ID:				

Comments:

Continued to page 2…

Contracted Entity Location Add/Remove Form

SCHA # 5079 (11/2023)

List all practitioners affiliated with the facility:

All practitioners must be credentialed with SCHA prior to being added to each location. To ensure credentialed practitioners are properly enrolled with the new site, please complete a Minnesota Uniform Practitioner Change Form.

If a practitioner is new or has not started, please complete, and submit the Minnesota Uniform Credentialing Application on the Minnesota Credentialing Collaborative (MCC) web portal - Minnesota Credentialing Collaborative > Home (mncred.org).

Add or Remove	Last Name	First Name	MI	Degree	Specialty	NPI/UMPI
Please Select						
Please Select						
Please Select						
Please Select						
Please Select						
Please Select						
Please Select						

Is the new location a primary care location: ☐ Yes ☐ No

If yes, please check the following box that is applicable to your location.

☐ Family Practice ☐ Internal Medicine ☐ Pediatric ☐ OB/GYN

Hospital privileges (where do you admit your patients to)?

Please check: ☐ New location ☐ Existing location

Check all special restrictions you have:

☐ Age/gender restrictions: ***please list***:
☐ For American Indians only
☐ No nursing home visits
☐ Not accepting new patients
☐ Nursing home residents only
☐ Provide only telehealth services

If you are a family practice location, please check all special services you provide:

☐ Behavioral health	☐ Pharmacy	☐ Midwives	☐ Female providers
☐ Dental services	☐ WIC on site	☐ OB care on site	☐ Multi-specialty
☐ Mammogram	☐ Child care on site	☐ Public health nursing	☐ Optical
☐ Nutrition	☐ Education classes	☐ Chiropractic care	☐ Ultrasound

Completed by:	**Date:**
Contact Person's Phone Number:	**Email Address:**