



Submit completed form to: Office of Provider Services
Email: BHcredentialing@cchealth.org - or - Fax: (925) 608-6794

Contra Costa County Behavioral Health
FACILITY/PROGRAM ASSIGNMENT FORM

This form can be used in lieu of the Credentialing Change Form to request that up to 10 providers within your organization be assigned to a specified facility and program. Please submit a copy of the attached 274 Report Provider Information Form (MHA22h) for each provider listed below.

Note: When requesting facility changes for an individual provider, please use the Credentialing Change Form (Form MHA22a) instead.

Section I: Facility and Program Information

Please list the Facility and Program where the providers should be authorized to bill for services.

Facility ID: Facility Name:

Program ID: Program Name:

Section II: Providers To Be Assigned

Please list all providers that should be assigned to the facility and program in section I. Include the provider's name, ShareCare ID, and the Start Date that should be used for the facility/program authorization.

Table with 5 columns: Number, Provider Name (Last, First), Credential Type (DMHW, LMFT, RN, etc), ShareCare ID, Start Date for Authorization. Rows 1-10.

Section III: Contact Information and Signature

MANAGER APPROVAL REQUIRED FOR FACILITY ADDS & CHANGES:

Print Name: Signature: Date: (Stamped or Electronic Signature Is Not Acceptable)

Send confirmation of change to: Name: Email:

Section IV: For Provider Services Use Only

- Update ShareCare, Update Provider Directory, Add to Tracking Sheet, Send Confirmation

Date Received: Completed by: Date: