RESET FORM

Contra Costa Mental Health Plan

SHARECARE ID REQUEST FORM

PLEASE COMPLETE ALL SECTIONS AS APPLICABLE TO PREVENT DELAYS IN PROCESSING

NO BILLING IS ALLOWED until verification and credentialing is finalized.
NO RETROACTIVE BILLING WILL BE ALLOWED

Section I. To be completed by staff

LEGAL NAME: ____________________ ____________________ ____________________
First Name Middle Name Last Name

DOB: ______________ Gender: Female Male NPI: ______________ Taxonomy: ______________

DISCIPLINE: ______________ LICENSE #: ______________

EXP DATE: ______________ STATE: ________

YOU MUST ATTACH A COPY OF YOUR LICENSE OR OTHER DOCUMENTATION REQUIRED FOR YOUR LICENSE

PHYSICIAN DEA#: ____________ EXP DATE: ____________

PHYSICIAN UPIN:____________

YOU MUST ATTACH A COPY OF YOUR DEA REGISTRATION

STAFF LANGUAGES:

	Please check one:
English	☐ Certified ☐ Fluent
Other Languages:	
	☐ Certified ☐ Fluent
	☐ Certified ☐ Fluent

ETHNICITY:

	White		Mexican American/Chicano		Chinese		Cambodian		Other Non-White
	Black		Latin American		Vietnamese		Japanese		Unknown
	Native American		Other Spanish		Laotian		Filipino		Other Southeast Asian

EMPLOYMENT START DATE:____________ **Staff Signature** ____________________________ Date: ____________

(Stamped or Electronic Signature Is Not Acceptable)

Section II. To be completed by supervisor/manager

Staff Type: ☐ Direct Service Provider ☐ Administrative Staff ☐ TBS Worker

Contractor/Supervisor/Manager: ______________________________ Program Name: ______________________________

Notification of Staff # Assignment to: ______________________________ Phone Number: ______________________________

EMAIL: ______________________________

Facility Authorization Requested for the following:

Facility ID #____________Program ID #__________ Facility ID #____________Program ID #__________
Facility ID #____________Program ID #__________ Facility ID #____________Program ID #__________

Section III. To be completed by Contra Costa Provider Services Unit

FOR CCC PROVIDER SERVICES USE ONLY	**Psychiatrist:** ☐ DO ☐ MD
	Nursing: ☐ Nurse Practitioner ☐ Registered Nurse ☐ Psychiatric Technician
	Licensed Mental Health Professional: ☐ Marriage & Family Therapist ☐ Social Worker ☐ Psychologist [☐ PhD ☐ PsyD] ☐ LPCC
APPROVED START DATE:	**Intern:** ☐ Associate Marriage & Family Therapist ☐ Associate Social Worker ☐ Psychologist Intern ☐ Associate Prof Clinical Counselor
	Trainees: ☐ Marriage & Family Therapist Trainee ☐ Social Work Trainee ☐ Psychologist Trainee ☐ PCC Trainee
__________	Mental Health Rehabilitation Specialist Designated Mental Health Worker TFC Parent Administrative Staff

SEND TO: Mental Health Administration
1340 Arnold Dr., Ste. 200
Martinez, CA 94553

FAX: (925) 957-5217

EMAIL: Provider.Services@cchealth.org