**County of Santa Cruz Mental Health and Substance Abuse Services**

# MHE 85 Avatar Practitioner ID Request Form Contractor Agency

# Use this form for Practitioner-Billing ID# Only. Use MHE 87 if Avatar User-Practitioner access is needed

# (Do not use this form for County Employees. County Employees must use Form MHE 10)

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| Section 1: Completed by Contracting Agency |
| **(Questions below must be answered in the far right column with Yes / No / NA / or written Answer)** |
| NAME OF CONTRACTING AGENCY |  |
| AGENCY STREET ADDRESS |  |
| AGENCY CITY, STATE, ZIP |  |
| AGENCY PHONE NUMBER |  |
| PRACTITIONER FIRST NAME |  |
| LAST NAME  |  |
| MIDDLE INITIAL |  |
| SOCIAL SECURITY# *(required for DHCS Compliance/Auditing)*  |  |
| GENDER  |  |
| DATE OF BIRTH |  |
| FIRST WORKING DATE  |  |
| INDIVIDUAL NPI # (National Provider Identifier #) |  |
| INDIVIDUAL NPI # Taxonomy Code Assigned |  |
| ETHNICITY  |  |
| LANGUAGES SPOKEN (other than English) |  |
| TYPE OF WORK (for instance: MD, NP, RN, IMF, ASW, Counselor) |  |
| CLINICAL LICENSE #, CERTIFICATION # or Registration# with BBS (if none, then indicate this)  |  |
| LICENSE/CERT/REG EXPIRATION DATE  |  |
| LICENSE/CERT/REG AUTHORITY *(other than State of California)* |  |
| NAME OF SUPERVISOR OR MANAGER  |  |
| NAME A CURRENT EMPLOYEE WHO DOES THE SAME JOB  |  |
| PHONE NUMBER WHERE PRACTITIONER CAN BE REACHED *(Contact number if we need to obtain copy of license(s) for credentialing purposes).*  |  |
| PROGRAM ASSOCIATION #1 *(refer to list of Programs for your Agency, or specify “All Programs”)* |  |
| PROGRAM ASSOCIATION #2  |  |
| PROGRAM ASSOCIATION #3 *(if more, list the rest here, separate with commas)*  |  |
| **(All questions below must be answered with Yes / No / and check ALL that apply**  |
| **1. Does practitioner need Waiver Application?**  | **[ ]** **NO** | **[ ]** **YES** | **If YES check one from below. The appropriate waiver and guidelines will be sent.**[ ]  IMFT [ ]  ASW [ ]  PCCI [ ]  Psychologist Assoc.  | **2.** **LOCAL** Santa Cruz County **ONLY**: Does practitioner need an application for MH Rehabilitation Specialist (MHRS):NO [ ]  YES [ ]  |
| Form Completed By:       Date Submitted:       Notes/Comments:      |
| Section 2: CoMPleted by County Staff |
| **Avatar Practitioner ID #       Date Entered:       Entered By:       Copy Routed to QI:** |

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