CAMHD CREDENTIALING

REQUEST TO UPDATE / CHANGE

# CURRENT PRACTITIONER INFORMATION

# all fields required

|  |  |  |  |
| --- | --- | --- | --- |
| Date of Request | Click or tap here to enter text. | Agency Name | Click or tap here to enter text. |
| Practitioner Current Legal First Name | Click or tap here to enter text. | Practitioner Current Legal Last Name | Click or tap here to enter text. |
| Current Credentialing Code | Click or tap here to enter text. | Current NPI Number (if applicable) | Click or tap here to enter text. |
| Current Position Title | Click or tap here to enter text. | Servicing Location (Island/Islands) | Click or tap here to enter text. |

# UPDATED INFORAMATION

# Indicate updates or changes as applicable in this section

|  |  |  |  |
| --- | --- | --- | --- |
| Updated Practitioner First Name | Click or tap here to enter text. | Updated Practitioner Last Name | Click or tap here to enter text. |
| Updated Higher Completed Education / Degree / Certificate(Attach verification / transcript) | Click or tap here to enter text. | Requested Credentialing Level (For MHP to QMHP upgrades, submit Initial file) | [ ]  Paraprofessional 1[ ]  Paraprofessional 2(Attach Experience Worksheet, Resume, and NPI)[ ]  MHP(Attach Experience Worksheet and Resume) |
| Updated Position Title (If the same, list current job title) | Click or tap here to enter text. |
| Updated Licensure(Attach new license verifications and NPDB) | Click or tap here to enter text. | NPI Verification(Required for all MHPs, QMHPs, PARA 2s or PARA 1s servicing CMO, FFT, IIH, IILS, and MST) | Click or tap here to enter text. |
| Adding Level of Care  | [ ]  Crisis Mobile Outreach (CMO) | [ ]  Intensive In-Home (IIH) | [ ]  Intensive Independent Living Skills (IILS) |
| [ ]  Transitional Family Home (TFH) | [ ]  Functional Family Therapy (FFT) | [ ]  Multisystemic Therapy (MST) |
| [ ]  Community-Based Residential (CBR) | [ ]  Hospital-Based Residential (HBR) | [ ]  Other:  |
| Other Requests | Click or tap here to enter text. |

# REQUESTOR

|  |  |  |  |
| --- | --- | --- | --- |
| Requested By | Click or tap here to enter text. | Effective Date of Change/Update | Click or tap here to enter text. |

# agreement

1. By submitting this application, you authorize CAMHD CREDENTIALING to make inquiries into the updates/changes that you have requested
2. Submit completed form to the CAMHD Credentialing Specialist Kat Moratin via email at Christina.moratin@doh.hawaii.gov
3. Be sure to include all supporting documentation as required above

# for camhd credentialing use only

|  |  |
| --- | --- |
| Status |  |
| Completed By |  |
| Date |  |  |  |