RESET FORM

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

CONTRA COSTA HEALTH

Contra Costa County Behavioral Health

STAFF TERMINATION FORM

When a provider leaves your agency or no longer works in a position that provides billable services, please submit this form. The Provider Services Unit will use the information below to end all applicable facility authorizations.

Section I: Provider Information

Legal Name: _____ _____ _____ **Birthdate:** _____
Last *First* *Middle*

ShareCare ID: _____

Classification: ☐ MD ☐ NP ☐ RN ☐ LPT ☐ Licensed Psychologist ☐ LMFT ☐ LCSW ☐ LPCC ☐ Waivered Psychologist ☐ AMFT ☐ ASW ☐ APCC ☐ Trainee ☐ MHRS ☐ DMHW ☐ TFC Parent

Section II: Facility & Program Information

Indicate the effective date and all facilities and programs where the provider's authorizations should be ended:

Effective Date: _____ ***(****Last day of authorization to bill for facilities/programs listed below)*

☐ **Contracted CBO** *(Community Based Organization)*
Agency Name: _____

- OR -

☐ **County Owned & Operated Facility**
Clinic/Office: _____

☐ For this provider, end authorizations for ALL facilities and programs with my agency.

- OR -

☐ For this provider, end authorizations for the specific facilities and programs listed below.
Any additional facility/program authorizations with my agency that are not listed below will remain active.

1. Facility ID: _____ Facility Name: _____ Program ID: _____ Program Name: _____
2. Facility ID: _____ Facility Name: _____ Program ID: _____ Program Name: _____
3. Facility ID: _____ Facility Name: _____ Program ID: _____ Program Name: _____

Requested By: _____ Email: _____

Section III: For Provider Services Use Only

☐ End facility authorizations in ShareCare
☐ Add note to ShareCare
☐ Add to Tracking Sheet
Note: Provider Directory will be updated based on information in Tracking Sheet

Date Received: _____ Completed by: _____ Date: _____