

Instructions for Group Practice or Individual Provider updates or Provider Directory inaccuracies.

Ventura County Health Care Plan (VCHCP) providers can submit inquiries or provider directory inaccuracies to the Plan via the website (<http://www.vchealthcareplan.org>), email, fax or USPS.

Provider Directory Error Inquiry (via Website)

Ventura County Health Care Plan (VCHCP) providers have the ability to use the online form via the website if they need to submit an inaccuracy identified in the directory data. This is located at “Find a Provider” at: <http://www.vchealthcareplan.org/members/physicians.aspx>

The screenshot displays the Ventura County Health Care Plan website. At the top, there is a navigation bar with links: Home, Benefit Plans, Search for Contracted Providers, Health Education Information, Contact Information, and Forms. Below this, a 'Find a Provider' section is visible, updated as of July 28, 2016. A 'Quick Links' menu on the right includes: HPAIA Letter and Notice of Privacy Practices, GRIEVANCE FORM, Report Error Online Form, Report Error PDF Form, and Provider Update Request Form. An arrow points from the 'Report Error Online Form' link to the 'Report Error' form below. The form is titled 'I would like to report an inaccuracy within the Provider Directory.' and contains fields for: First Name, Last Name, Address, City, State, Zip Code, Telephone, and Email Address. Below these fields, there is a section for 'Please provide details of the provider directory inaccuracy.' with checkboxes for: Address, Office is closed to New Members, Telephone, Provider is no longer there, No longer accepting the Plan, and Email Address. There is also a text box for 'Other:'. Further down, there are fields for 'Name of Group/Individual Provider:', Address, City, State, Zip Code, Telephone, and Email Address. At the bottom, there is a text box for 'Additional Information:'. The form concludes with three buttons: 'Start Over', 'Print', and 'Submit'. An arrow points from the 'Submit' button to the third step in the instructions.

1. Click on The Report Error Online Form

2. Complete the form with the appropriate information

3. Submit by clicking the “submit” button

Providers/Office Managers will receive an email acknowledging the request and a status regarding the outcome. Please provide a valid email address.

Provider Directory Error Inquiry (via Email)

VCHCP providers can initiate an update by sending a completed Provider Update Request Form to the shared mailbox at VCHCP.Provider.Services@Ventura.org. The form is located on the website on the “Find a Provider” page listed above or the “Provider Connection” page at: <http://www.vchealthcareplan.org/providers/providerIndex.aspx>.



Provider Update Request Form

| Current Practice information | | |
|--|---|--|
| Effective Date of Change: _____ | <input type="checkbox"/> Group Practice | <input type="checkbox"/> Individual Provider |
| Name of Group/Individual Provider: _____ | | |
| NPI #: _____ | TAX ID #: _____ | |
| Practice Address: _____ | | |
| City: _____ | State: _____ | Zip Code: _____ |
| Telephone: _____ | Fax: _____ | Email: _____ |

| Provider Change Information | | |
|--|---|---|
| Type of Change: | | |
| <input type="checkbox"/> Address/Billing Change | <input type="checkbox"/> Telephone/Fax Number | <input type="checkbox"/> Email Address |
| <input type="checkbox"/> Closed/Open to New Members | <input type="checkbox"/> NPI Change | <input type="checkbox"/> Tax ID Change |
| <input type="checkbox"/> Adding a Location | <input type="checkbox"/> Adding a Provider | <input type="checkbox"/> Termining a Provider |
| New Office Information: | | |
| Name of Group/Individual Provider: _____ | | |
| NPI #: _____ | Tax ID #: _____ | |
| Practice Address: _____ | | |
| City: _____ | State: _____ | Zip Code: _____ |
| Telephone: _____ | Fax: _____ | Email: _____ |
| Providers – Please list providers that have been added or deleted from your practice. | | |
| Last Name: _____ | First: _____ | Middle: _____ Degree: _____ |
| NPI #: _____ License #: _____ | | |
| Last Name: _____ | First: _____ | Middle: _____ Degree: _____ |
| NPI #: _____ License #: _____ | | |
| Change of Ownership: | | |
| Legal Business Name of New Owner: _____ | | |
| Tax ID Number of New Owner (Requires W-9 Form): _____ | | |
| Authorized by: | | |
| Name: _____ | Title: _____ | |
| Signature: _____ | Date: _____ | |

Please email, mail, or fax this change form and supporting documentation to: Provider Services Department at VCHCP.ProviderServices@Ventura.org; 2220 E. Gonzales Rd. #210-B, Oxnard, CA. 93036; Fax: 805-981-5051.

If preferred, please faxed to 805-981-5051 or mail to Provider Services at 2220 E. Gonzales Rd. #210-B, Oxnard, California 93036. Inaccuracies can also be reported to VCHCP by calling 805-981-5050.