



Montana Healthcare Programs CSCT Contractor/Team Change Form

Montana Healthcare Programs considers the School to be the provider of these services. The information on record must be that of the school's.

To change a contractor for an existing Montana Medicaid file, complete this form for each CSCT Team and attach the signed CSCT Contract for the new Team. **Provider Relations will use the information below to create a new team file. Existing information for the school will be copied into the new file (i.e. Tax ID and Banking Data).** New/Additional Teams, or changes to Tax Reporting, will require **the school to submit** a new enrollment.

Mail or Fax this form to:
Provider Relations Enrollment
PO Box 4936
Helena, MT 59604
Fax (406) 442-4402

Section I

The following will be used to identify update and termination of the correct Team record:

National Provider Identification (NPI) _____
School or District NPI used for billing

Name of School _____
Will be entered as Provider Name

Name of Current CSCT Contractor _____
To identify existing file to extract data from and terminate

Current Assigned Team Number _____ **Contract End Date** _____

Physical Address of School: _____

City _____ **Zip+4** _____

County _____

School Phone _____ **School Fax** _____

Section II

The following will be used to create the new Team record:

New CSCT Contractor _____ **New Contract Effective Date** _____
Will be entered on Address Line 1 of Provider Record *Will be used for the new file's effective date*

Correspondence Address of CSCT Contractor
Will be entered as Address 3 of the Provider Record

City _____ **Zip+4** _____

A new Team Number and Provider Number will be created on behalf of the School using the above information. Please supply a school contact to verify the data on file prior to final approval. Further documentation may be requested.

School Contact Name: _____ **School Contact Email:** _____