Health Care Agency/Public Health Services
Comprehensive Perinatal Services Program (CPSP)
P.O. Box 6099, Santa Ana, CA 92706 **Email:** CPSP@ochca.com
Phone: (714) 567-6236 **Fax:** (714) 834-7780

Request for Local Coordinator's Approval of Changes to Previously Approved Application

CPSP Practice/Clinic Name: ______________________________ Date: ______________

Address: ______________________________ Email: ______________________________

Contact Person: ______________________ Phone: ______________ Fax: ______________

I request approval of changes to my CPSP provider's application (check all that apply)

Change:	Delete:	Add:
☐ Provider Name/Ownership	☐ Staff	☐ Staff
☐ Address	☐ Supervising MD	☐ Supervising MD
☐ NPI	☐ Description of Practice	☐ Description of Practice
☐ Primary Contact Person	☐ Referrals	☐ Referrals
☐ Telephone Number	☐ Hospitals for Planned Delivery	☐ Hospitals for Planned Delivery
	☐ Transfer of Care Agreements	☐ Transfer of Care Agreements

Please review the form carefully and complete each item requested. An incomplete form will be returned. Email the completed form to CPSP@ochca.com.

Delete from application	Requesting to Change/Add
Provider Name:	Provider Name:
Address:	Address:
NPI:	NPI:
Primary contact person:	Primary contact person:
Telephone number:	Telephone number:
Supervising MD:	Supervising MD:
Description of practice:	Description of practice: (must attach description of practice)
Referrals:	Referrals:
Hospital for planned delivery:	Hospital for planned delivery:
Transfer of care agreement:	Transfer of care agreement: (must attach transfer of care agreement)

CPSP Practice/Clinic Name: ______________________ Date: ______________________

National Provider Identifier: ______________________

PRACTITIONERS PROVIDING CPSP SERVICES (list all staff currently providing CPSP services including qualifications)

(A) PRACTITIONER NAME	(B) CPSP PRACTITIONER TYPE (MD/DO, CNM, NP, PA, LM, RN, LVN, SW, PSY, MFT, RD, HE, CCE, CPHW)	(C) PRACTITIONER QUALIFICATIONS	(D) SERVICE(S) PROVIDED* OB	B	CO	HE	N	PSY	CC	CON	P	(E) YRS OF EXP.
	Select One	LIC/CERT/REG#: ____ SCHOOL: ____ DEGREE: ____ YEAR: ____										____
	Select One	LIC/CERT/REG#: ____ SCHOOL: ____ DEGREE: ____ YEAR: ____										____
	Select One	LIC/CERT/REG#: ____ SCHOOL: ____ DEGREE: ____ YEAR: ____										____
	Select One	LIC/CERT/REG#: ____ SCHOOL: ____ DEGREE: ____ YEAR: ____										____
	Select One	LIC/CERT/REG#: ____ SCHOOL: ____ DEGREE: ____ YEAR: ____										____
	Select One	LIC/CERT/REG#: ____ SCHOOL: ____ DEGREE: ____ YEAR: ____										____
	Select One	LIC/CERT/REG#: ____ SCHOOL: ____ DEGREE: ____ YEAR: ____										____
	Select One	LIC/CERT/REG#: ____ SCHOOL: ____ DEGREE: ____ YEAR: ____										____
	Select One	LIC/CERT/REG#: ____ SCHOOL: ____ DEGREE: ____ YEAR: ____										____
	Select One	LIC/CERT/REG#: ____ SCHOOL: ____ DEGREE: ____ YEAR: ____										____

Authorized agent name:	Signature:	Date:

* OB = Obstetrics/Gynecology | B = Backup Physician | CO = Client Orientation
HE = Health Education | N = Nutrition | PSY = Psychosocial
CC = Case Coordination | CON = Consultation | P = Protocol Approval