BEHAVIORAL HEALTH SYSTEMS

Behavioral Healthcare Programs for Business & Industry Since 1989

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Treatment Provider Recredentialing Application

Identifying Information (Please type or print)

Provider's Name		Degree/Title ❑ MD ❑ DO ❑ PhD ❑ PsyD ❑ LPC ❑ LCSW ❑ LMHC ❑ MFT ❑ CNP ❑ Other _____
Gender (Optional) ❑ Male ❑ Female	Race/Ethnic Group (Optional) ❑ American Indian ❑ Asian ❑ Black ❑ Hispanic ❑ White ❑ Other _____	

Date of Birth	Social Security Number	UPIN	NPIN

Address Information (Please list all locations and group affiliations. Use an additional attachment if needed.)

Primary Office

Practice Type ❑ Solo ❑ Group ❑ Employee ❑ Independent Contractor ❑ Other _____		
Practice/Business Name		
Street Address		
Suite #	City	
State	Zip	County
Phone	Fax	Emergency
Federal Tax ID Number	Email	
Normal Business Hours	Schedule (Check all that apply to this location.) ❑ S ❑ M ❑ T ❑ W ❑ T ❑ F ❑ S	

Mailing Address (if different)

Practice Name		
Street Address		Suite #
City	State	Zip
Phone	Fax	Email

Additional Office Information

Practice Type ❑ Solo ❑ Group ❑ Employee ❑ Independent Contractor ❑ Other _____		
Practice/Business Name		
Street Address		
Suite #	City	
State	Zip	County
Phone	Fax	Emergency
Federal Tax ID Number	Email	
Normal Business Hours	Schedule (Check all that apply to this location.) ❑ S ❑ M ❑ T ❑ W ❑ T ❑ F ❑ S	

Claims Payment Address (if different)

Practice Name		
Street Address		Suite #
City	State	Zip
Phone	Fax	Email

Licensure (Please list current licensure information.)

Type	State	Number	Expiration Date
State License			
State License			
CDS			
Federal DEA	US		
National Certification			

Professional Liability Insurance (Please attach a copy of your current professional liability insurance certificate or declaration page showing dates and amounts of coverage.)

Current Insurance Carrier		
Policy #	Amounts of Coverage $ Occurrence / $ Aggregate	
Effective Date	Expiration Date	Years with Carrier
Patient Compensation Fund (if applicable)		
Effective Date	Expiration Date	Coverage Amount $

Office Site Assessment (Please check all that apply to the physical office location.)

Standard	Office 1	Office 2
Private entrance		
Private waiting area		
Handicap accessible		
Accessible by public transportation		
Off-street parking available		
Free parking		
Lighted parking		
Smoke-free office		

Hospital Information (List your present hospital affiliations.)

Hospital Name	
Address	
Status	Department
Hospital Name	
Address	
Status	Department

Practice Information Please indicate the percent of your current caseload which falls into each of the following categories:

Client Groups

Child _____**%** Adolescent _____**%** Adult _____**%** Geriatric/Elderly_____**%**

Client age range: Minimum age: _____ Maximum age: _____ What percent of total caseload, if any is substance abuse? _____**%**

Are you accepting new patients? ❑ Yes ❑ No

Specialty/Treatment Categories (Please check all that apply.)

	Abortion Issues		ECT (MD only)		Parenting Issues
	Acculturation Problem		Emergency Assessment		Phase of Life Problem
	Acute Signs/Symptoms of Abuse Victim		Family Systems Therapy		Psychological Factors Affecting Physical Conditions
	ACOA/Codependency		Forensics		
	AIDS Issues		Grief Issues		Psychological Testing
	Assertiveness		Habit Control		Psychopharmacology
	Autism		Hispanic Issues		Reality Therapy
	Black Issues		Identity Problem		Relocation Counseling/Out-Placement
	CEAP		Insight Therapy		Return to Work Evaluations/Disability
	Cognitive–Behavioral Therapy		Intervention, Non-Crisis		Rogerian (client/person centered) Therapy
	Conflict Resolution		Men's Issues		Solution-Oriented Therapy
	Consultation Liaison		Mental Retardation		Stress Management
	Couples /Relational Problem		Neuropsychology		Substance Abuse Solutions/Treatment
	Crisis Intervention		Occupational Problem		Suicide Prevention
	Critical Incidents		On-Site Testing		Travel Ability
	Domestic Violence		Other Addictions		Women's Issues
	DOT-Approved SAP		Pain Management		

Presenting Problems (Please check the disorders you treat most frequently.)

- ❑ Adjustment Disorder
- ❑ Anxiety Disorder
- ❑ Child & Adolescent Disorder
- ❑ Disorders due to General Medical Conditions
- ❑ Delirium
- ❑ Dissociative Disorder
- ❑ Eating Disorder
- ❑ Impulse Control Disorder
- ❑ Mood Disorder
- ❑ Personality Disorder
- ❑ Schizophrenia/Psychotic Disorder
- ❑ Sexual/Gender Identity Disorder
- ❑ Somatoform Disorder (Pain Management)
- ❑ Substance Abuse Disorder
- ❑ Other _____
- ❑ Other _____

Specialized Treatment – Do you meet criteria for treatment providers as detailed below for:

❑ Child/Adolescent ❑ Substance Abuse ❑ Critical Incident Stress Debriefing
❑ Disability Management /Workers Compensation ❑ Applied Behavior Analysis

Criteria for Child /Adolescent: Providers with a child/adolescent specialty must meet the following qualifications:

A. Current active child/adolescent caseload averaging 33% or more.
B. Experience in court hearing process desirable.
C. A minimum of 4 – 6 hours continuing education specific to treatment of children/adolescents per licensure period.

Criteria for Substance Abuse: Providers with a substance abuse specialty must meet the following qualifications:

A. Certification as an Addictions Specialist, or two years post-degree clinical (direct care) experience in the field of substance abuse, as defined by association with a formal, structured substance abuse program or carrying a caseload of at least 33% substance abuse cases.
B. Current active substance abuse caseload averaging 33% or more.
C. A minimum of 4 – 6 hours continuing education specific to substance abuse per licensure period.

Criteria for Critical Incident Stress Debriefing: Providers with a critical incident stress debriefing specialty must meet the following qualifications:

A. Documented completion of a group debriefing course, or two Critical Incident Stress Debriefing cases done within the past two years.

Criteria for Disability Management/Workers Compensation: Providers with a disability management/workers compensation specialty must meet the following qualifications:

A. Two years post-degree clinical (direct care) experience in the field of disability management/workers compensation.

Criteria for Applied Behavior Analysis: Providers with an Applied Behavior Analysis specialty must meet the following qualifications:

A. Certification through Behavior Analysis Certification Board as BCBA or BCBA-D; or BCaBA or RBT supervised by BHS-approved BCBA.
B. Current active ABA caseload pertinent to Autism Spectrum Disorders averaging 50% or more.
C. Continuing education specific to ABA.

Board Certification

Are you Board Certified? ❑ Yes ❑ No

Specialty:	Exp Date
Specialty:	Exp Date

National Certification(s)

Do you hold any National Certifications? ❑ Yes ❑ No

Certifying Board Name	Cert. Number	Exp. Date
Certifying Board Name	Cert. Number	Exp. Date

Mandatory Questionnaire

IMPORTANT: If any of the following questions is answered "Yes", please provide a summary below or attach an explanation for each answer. If any questions do not apply to you, please answer "No". **Failure to respond or provide explanations for "Yes" responses may result in delay of application processing.**

Licensure Information

Since your last credentialing cycle:

1. Have you been censured, reprimanded, or had disciplinary action taken by an ethical standards committee, licensing board, or other board of inquiry, or is any such action currently pending or under investigation? ❑ Yes ❑ No
2. Have you voluntarily surrendered your professional license, had your professional license revoked, suspended, or limited, or worked under a probationary license or consent agreement? ❑ Yes ❑ No
3. Have you been the subject of any investigation by any private, federal, or state health program or is any such action pending? ❑ Yes ❑ No
4. Has your Federal DEA and/or State Controlled Dangerous Substance (CDS) Certificate(s) been voluntarily or involuntarily limited, suspended, revoked, surrendered, or not renewed, or is any such action currently pending? ❑ Yes ❑ No

Hospital and Other Affiliations

Since your last credentialing cycle:

1. Have you been denied hospital privileges? ❑ Yes ❑ No
2. If you were granted hospital privileges, were they voluntarily or involuntarily limited, suspended, revoked, or denied renewal, or is any such action currently pending, or has any such action been recommended? ❑ Yes ❑ No
3. Have you resigned from, or withdrawn an application for privileges or membership with, the staff of any hospital or medical organization because of problems regarding privileges or credentials, or is any such action currently pending? ❑ Yes ❑ No
4. Has your membership in any professional organization been revoked, suspended, or terminated involuntarily for any reason other than failure to pay membership fees, or is any such action currently pending? ❑ Yes ❑ No

Criminal History

Since your last credentialing cycle:

1. Have you been indicted for, convicted of, or pleaded guilty to a crime, or are you presently under investigation for a crime? ❑ Yes ❑ No
2. Have you entered into a consent agreement, entered a plea of guilty, or been found guilty of, fraud or abuse involving payment of health care claims by any health care payor or been sanctioned by any third party payor or health care claims or professional review organization, governmental entity or agency, or is any such action pending? ❑ Yes ❑ No

Insurance Information

Since your last credentialing cycle:

1. Has your professional liability insurance coverage been involuntarily terminated, or modified by action of any insurance company? ❑ Yes ❑ No
2. Have you been denied or refused renewal of professional liability coverage, rated in a higher-than-average risk class for your specialty, or had a surcharge relative to claims? ❑ Yes ❑ No
3. Have you filed a claim under your professional liability insurance, have any suits, actions, or claims alleging malpractice been filed, or are there any pending against you? ❑ Yes ❑ No
4. Have you filed a claim under your general liability insurance, have any suits, actions, or claims been filed, or are there any pending against you? ❑ Yes ❑ No
5. Have any judgments been made against you in professional liability cases or claims, or have you entered into any settlements? ❑ Yes ❑ No
6. To your knowledge, has information pertaining to you been reported to the National Practitioner Data Bank or the Healthcare Integrity and Protection Data Bank? ❑ Yes ❑ No

Health Status

Since your last credentialing cycle:

1. Are you currently using any illegal drugs? ❑ Yes ❑ No
2. Have you been under the influence of alcohol during working hours, or have you used drugs illegally? ❑ Yes ❑ No
4. Do you suffer from any medical or mental health condition which impairs your ability to practice to the fullest extent of your license, qualifications, and privileges with or without reasonable accommodations? ❑ Yes ❑ No
5. Have you received any mental health treatment for a diagnosis identified in DSM-IV-TR which was ordered by an ethical standards committee, licensing board, or other board of inquiry? ❑ Yes ❑ No
6. Have you voluntarily participated in a rehabilitation program or other treatment for substance abuse? ❑ Yes ❑ No

Comments (Please provide an explanation to any "Yes" answer given above. Attach a separate sheet if you need additional space.)

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Certification, Authorization and Attestation

I acknowledge and agree that Behavioral Health Systems, Inc. (BHS) has a valid interest in obtaining and verifying information concerning my professional competence, in determining whether to enter into an agreement with me for the provision of services to members.

I represent and certify to BHS that the information contained in this Application is true and complete to the best of my knowledge and belief, that I meet the BHS Criteria set forth above and, if applicable, the Assessment/Case Manager Criteria, for those specialties I have indicated on the Application, and I agree to inform BHS promptly if any material change in such information occurs, whether before or after acceptance by BHS of my Application for affiliation with BHS' provider network.

I understand and agree that I have the burden of producing adequate information for proper evaluation of my professional qualifications, credentials, clinical and mental competence, clinical performance, ethics, or any other matter that might directly or indirectly have an effect on my competence, performance, or patient care and for resolving any reasonable questions regarding such qualifications, and that BHS has no responsibility to consider this Application until all necessary information is received by BHS.

I authorize BHS to consult with state licensing boards, hospital administrators, members of staffs of hospitals, malpractice carriers and other persons to obtain and verify information concerning my professional competence, character and moral and ethical qualifications, and I release BHS and its employees and agents from any and all liability for their acts performed in good faith and without malice in obtaining and verifying such information and in evaluating my Application.

I consent to the release by any persons to BHS of all information that may reasonably be relevant to an evaluation of my professional competence, character and moral and ethical qualifications, including any information relating to any disciplinary action, suspension or curtailment of privileges, and hereby release any such person providing such information from any and all liability for doing so.

I warrant that I have the authority to sign this Application. I agree that submission of this Application does not constitute approval or acceptance as a participating provider.

I understand that any material misstatement, error, or omission in this Application shall constitute cause for denial of this Application and of my participation in the network. I further understand that if my Application is rejected for reasons relating to my professional conduct or competence, BHS may report the rejection to the appropriate state licensing board, National Practitioner Data Bank, Healthcare Integrity and Protection Data Bank, or other professional data bank(s).

Your signature is required to complete this Application. Stamped signatures are not acceptable.

Name (Please Print or Type)	**Signature**	**Date**