BEHAVIORAL HEALTH SYSTEMS
Behavioral Healthcare Programs for Business & Industry Since 1989
www.behavioralhealthsystems.com • Phone: 800-245-1150 • Fax: 205-879-1178
Corporate Office: Two Metroplex Dr., Ste 500, Birmingham, AL 35209 • **Midwest Office**: John Hancock Center, Ste 3137, 875 N. Michigan Ave., Chicago, IL 60611

Treatment Provider Application

Identifying Information (Please type or print.)

Provider's First Name	Provider Middle Name	Provider Last Name	Degree/Title or Licensure
Provider's Maiden Name	Provider's Other Name	Suffix	❑ MD ❑ DO ❑ PhD ❑ PsyD ❑ PA ❑ CRNP/APRN ❑ PMHNP ❑ FNP ❑ LCSW ❑ LMHC ❑ MFT ❑ LPC ❑ BCBA ❑ Other _____
Gender (Optional) ❑ Male ❑ Female	Race/Ethnic Group (Optional) ❑ American Indian ❑ Asian ❑ Black ❑ Hispanic ❑ White ❑ Other _____		

Date of Birth (Required)	Social Security Number (Required)	Individual NPI# (Required)
US Citizen (Required) ❑ Yes ❑ No	Legal Right to Work in the US (Required) ❑ Yes ❑ No	If No, Alien Registration number
City of Birth	State of Birth	Country of Birth (Required)

Address Information (Please list all locations and group affiliations.)

Primary Office

Practice Type
❑ Solo ❑ Group ❑ Employee ❑ Independent Contractor ❑ Other _____

Practice/Business Name

Street Address	Suite #

City	State	Zip	County

Office Phone	Scheduling Phone (if different)	Office Fax	Scheduling Fax (if different)

Office Email	Provider Email

Federal Tax ID Number	**Group NPI#**	Web Address

Office Contact Person	Normal Business Hours	Schedule (Check all that apply to this location.) ❑ S ❑ M ❑ T ❑ W ❑ T ❑ F ❑ S

Virtual only? ❑ Yes ❑ No	Is this location a home office? ❑ Yes ❑ No	If yes, does it have a separate entry? ❑ Yes ❑ No	Is this office completely separate from the living quarters? ❑ Yes ❑ No

Credentialing Contact Person (Required)	Credentialing Contact Phone	Credentialing Contact Email (Required)

Office Accommodations (Please check all that apply.) ❑ Private Waiting Area ❑ Handicapped Accessible ❑ Smoke-Free ❑ Fire Exits ❑ Fire Extinguisher ❑ Fire Plan ❑ Free Parking ❑ Lighted Parking ❑ Off-Street Parking ❑ Public Transportation ❑ Sign Language ❑ Hearing Impaired w/Translator ❑ TTY ❑ Locked Medication Storage ❑ Locked Records Storage

Mailing Address (if different)

Street Address or PO Box	Suite #

City	State	Zip

Phone	Fax

Claims Payment Address (if different)

Street Address or PO Box	Suite #

City	State	Zip

Phone	Fax

Additional Address Information

Practice Type
❑ Solo ❑ Group ❑ Employee ❑ Independent Contractor ❑ Other _____

Practice/Business Name			
Street Address			Suite #
City	State	Zip	County
Office Phone	Scheduling Phone (if different)	Office Fax	Scheduling Fax (if different)
Office Email	Provider Email		
Federal Tax ID Number	**Group NPI#:**	Web Adress	
Office Contact Person	Normal Business Hours	Schedule (Check all that apply to this location.) ❑ S ❑ M ❑ T ❑ W ❑ T ❑ F ❑ S	
Virtual only? ❑ Yes ❑ No	Is this location a home office? ❑ Yes ❑ No	If yes, does it have a separate entry? ❑ Yes ❑ No	Is this office completely separate from the living quarters? ❑ Yes ❑ No
Credentialing Contact Person (Required)	Credentialing Contact Phone	Credentialing Contact Email (Required)	

Office Accommodations (Please check all that apply.) ❑ Private Waiting Area ❑ Handicapped Accessible ❑ Smoke-Free ❑ Fire Exits ❑ Fire Extinguisher ❑ Fire Plan ❑ Free Parking ❑ Lighted Parking ❑ Off-Street Parking ❑ Public Transportation ❑ Sign Language ❑ Hearing Impaired w/Translator ❑ TTY ❑ Locked Medication Storage ❑ Locked Records Storage

Mailing Address (if different)			**Claims Payment Address** (if different)		
Street Address or PO Box		Suite #	Street Address or PO Box		Suite #
City	State	Zip	City	State	Zip
Phone	Fax		Phone	Fax	

Medical Education/Professional Degree/Other Training

Type	Degree/Specialty	Name of School/University	City/State	Completion Date
Graduate/Medical School				
Internship				
Residency				
Fellowship				
Other Training				

Work History (Please list work history going back 10 years including month/year dates or please attach a CV reflecting work history including month/year dates (required). **Include a written explanation for any employment gaps greater than 6 months.)**

Current Practice	**Start Date**	**End Date**
Address:		
City	**State**	**Zip**
Phone:	**Fax:**	**County:**
Previous Group Practice	**Start Date**	**End Date**
Address:		
City	**State**	**Zip**

Phone:	Fax:	County:
Other Work History	**Start Date**	**End Date**
Address:		
City	**State**	**Zip**
Phone:	**Fax:**	**County:**

License History (Please list licensure information for the past 10 years.)

Type	State	License Type (i.e., MD, LPC, etc.)	Number	Issue/Renewal Date	Expiration Date
State License					
Other State License					
Other State License					
CDS					
Federal DEA	US				

Specialty Certifications

Are you board certified or do you hold specialized credentials? ☐ Yes ☐ No ☐ N/A

If yes, please list below and attach copy of certificate(s).

Certification Board	Specialty	Certification Number	Issue/Renewal Date	Expiration Date

Insurance Information (Please **attach** a copy of your **current** insurance certificates or declaration pages showing the dates and amounts of coverage.)

Professional Liability Insurance

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

General Liability Insurance

Current Insurance Carrier			Policy #
Amounts of Coverage $ Occurrence / $ Aggregate	Effective Date	Expiration Date	Years with Carrier

Hospital Privileges

Do you have hospital staff privileges? ☐ Yes (Indicate below.) ☐ No

Facility Name	Address, City, State & Zip Code	Affiliation Type

Languages

Do you speak a language other than English? ❑ Yes (If yes, please list below.) ❑ No

Specialty Services (You must meet criteria for treatment providers as detailed on page 6 for those checked). **CEUs may be required if provider meets specialty criteria.**

❑ General ❑ Child/Adolescent ❑ Substance Abuse

❑ Critical Incident Stress Debriefing ❑ Disability Management/Workers Compensation ❑ Applied Behavior Analysis

Practice Information

Please indicate the percentage of your current caseload which falls into each of the following categories. (**Your total caseload should add up to 100%.)**

Client Groups

(In order to qualify for the Child/Adolescent specialty or the Substance Abuse specialty, the provider must carry a child/adolescent or substance abuse caseload of at least **33**%). Please see page 6 for additional criteria information

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

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

Number of years at current practice _____ Number of years clinical experience _____

Percent of referrals from EAP _____% Managed care _____%

Treatment Modalities ❑ Individual ❑ Family/Marital ❑ Group (Types: _____)

Treatment Options ❑ In person ❑ Virtual

Number of hours per week in direct care activities: _____

Do you currently receive professional supervision? ❑ Yes ❑ No Ratio supervised/direct care hours: _____

To which area professionals do you refer? _____

Facility Referrals (Please indicate to which area facilities you refer.)

Patient Type	**Outpatient (IOP, PHP) Facilities**	**Inpatient**
General Adult		
Child/Adolescent		
Substance Abuse		
Eating Disorders		
Other Specialties		

Clinical Support Information (Select plans and certain services require BHS precertification. This information is required to process application.)

Are you willing to participate in periodic clinical reviews with BHS case managers regarding the clinical status and progress of BHS clients?	❑ Yes ❑ No
Are you willing to submit a brief client progress summary and/or treatment plan to BHS if requested?	❑ Yes ❑ No
Please answer the following questions if you checked Disability Management/Workers Compensation as a specialty.	
Do you have specialized education, experience or certification in evaluation or treatment for disability/workers compensation cases? If yes, please list:_____	❑ Yes ❑ No ❑ NA
Do you require psychological testing for evaluation of disability or workers compensation cases? If yes, please list standardized instruments used: _____	❑ Yes ❑ No ❑ NA

Specialty/Treatment Categories (Please check all that apply.)					
	Abuse & Trauma		Eating Disorders		Parenting Issues
	Acculturation Problem		ECT (MD only)		Psychological Testing
	ADHD		EMDR		PTSD
	Anger Management		Faith Based		Reality Therapy
	Applied Behavioral Analysis (ABA)		Family Therapy		Reproductive Issues
	Autism Spectrum Disorders		Forensics		Return to Work Evaluations/Disability
	Chronic Medical Conditions		Grief Issues		Rogerian Therapy
	Codependency		Insight Therapy		Solution-Oriented Therapy
	Cognitive–Behavioral Therapy		LGBTQIA+		Stress Management
	Conflict Resolution		Medication Assisted Treatment (MAT)		Substance Abuse
	Couples/Relational Problems		Men's Issues		Suicide Prevention
	Crisis Intervention		Neuropsychology		Telehealth
	Critical Incidents		Occupational Problem		Transcranial Magnetic Stimulation (TMS)
	Dialectical Behavioral Therapy (DBT)		Other Addictions		Women's Issues
	DOT-Approved SAP		Out-Placement/Relocation		Worker's Compensation
Other:					

Presenting Problems (Please check the disorders you treat most frequently.)
Only check Child & Adolescent and Substance Abuse if you meet criteria for those specialties. Please see page 6 for additional criteria information.

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

Availability

- ❑ Immediately (crises)
- ❑ 24 hours
- ❑ 48 hours
- ❑ 72 hours
- ❑ More than three days for appointment

Describe your back-up coverage:

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

In the last ten (10) years:

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

In the last ten (10) years:

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

In the last ten (10) years:

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

In the last ten (10) years:

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

In the last ten (10) years:

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
3. 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
4. In the last five (5) years, 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
5. In the last four (4) years, have you voluntarily participated in a rehabilitation program or other treatment for substance abuse? ❑ Yes ❑ No

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

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BHS CRITERIA FOR PROFESSIONAL PROVIDER NETWORK AFFILIATION

Part One

I. Providers must have at least one of the following:
   A. Masters degree in behavioral sciences/human services (i.e., psychology, counseling, social work, psychiatric nursing); or
   B. Doctoral degree in behavioral sciences/human services; or
   C. Medical degree with completion of ABMS-approved residency program in psychiatry or addictionology.

II. Providers must meet the following qualifications:
   A. State licensure in related discipline (not including an "associate" or other license status which requires [non-disciplinary] supervision with a goal of achieving full licensure). Masters-prepared individuals not currently licensed may satisfy this requirement with: (1) three years post-masters supervised clinical (direct care) experience and current employment in a community mental health center; or (2) certification as an employee assistance professional (CEAP) by the Employer Assistance Certification Commission (referrals to these individual may be limited to only EAP treatment/services).
   B. Continuing education at no less than the minimum level required by the state of licensure.
   C. Support a least restrictive treatment philosophy and a managed care approach.
   D. In practice at least 20 hours per week.

III. Providers with a **Child/Adolescent** specialty must meet the following qualifications in addition to those in I. and II. above:
   A. Current active child/adolescent caseload averaging 33% or more.
   B. A minimum of 4 – 6 hours continuing education specific to treatment of children/adolescents per licensure period.

IV. Providers with a **Substance Abuse** specialty must meet the following qualifications in addition to those in I. and II. above:
   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.

V. Providers with a **Critical Incident Stress Debriefing** specialty must meet the following qualification in addition to those in I. and II. above:
   A. Documented completion of a group debriefing course, or two Critical Incident Stress Debriefing cases done within the past two years.

VI. Providers with a **Disability Management/Workers Compensation** specialty must meet the following qualification in addition to those in I. and II. above:
   A. Two years post-degree clinical (direct care) experience in the field of disability management/workers compensation.

VII. Providers with an **Applied Behavior Analysis** specialty must meet the following qualifications in addition to those in I. above:
   A. Certification through the Behavior Analysis Certification Board as a Behavior Analyst (BCBA or BCBA-D), and comparable state licensure, if applicable. Board Certified Assistant Behavior Analysts (BCaBA) and Registered Behavior Technicians (RBT) who do not meet the qualifications in I. above may satisfy this requirement through the supervision of a BHS-approved BCBA or BCBA-D.
   B. Current active ABA caseload pertinent to Autism Spectrum Disorders averaging 50% or more.
   C. In practice at least 20 hours per week.
   D. Continuing education specific to ABA.

Part Two

Because Behavioral Health Systems (BHS) has the utmost concern about both the quality of care provided to the patient, and the patient's perception of that quality of care, and because BHS operates as a preferred provider organization rather than as a health maintenance organization, BHS is adopting the following criteria for its provider network. These criteria apply to all BHS providers, present and future. These criteria may be amended by BHS from time to time.

I. Licensure

A. The provider may not have had a revoked, suspended, limited, or probationary license, or worked under a consent agreement, within the past ten years, regardless of the state of issuance of such revocation, etc. BHS reserves the right to reduce this period for revocations, suspensions, limitations, probations, or consent agreements based on administrative infractions not directly impacting patient care.

B. An unlicensed practitioner working under the supervision of a licensed or certified mental health professional, may not have had any disciplinary action taken against him/her by the supervisory individual, employing organization, ethical standards committee, or licensing board.

C. The provider may not have received any form of mental health treatment for a diagnosis identified in DSM-V, or the most current version, which was ordered by an ethical standards committee, licensing board, or other board of inquiry within the past five years.

D. The provider may not have any actions or formal complaints pending or currently under investigation by any ethical standards committee, licensing board, or other board of inquiry or authority. (Provider status shall be suspended until the outcome is known.)

E. Physicians must be authorized under current state and federal certificates to prescribe class 4 pharmaceuticals, and may not be prohibited from prescribing class 2, 2N, 3, or 3N pharmaceuticals as a result of any disciplinary action by a state or federal agency.

II. Insurance

A. The provider, either as an individual practitioner or as an owner of a corporation, may not have had any substantive liability claims, settlements, or judgments within the last ten years. However, lawsuits against a provider who is named *solely* due to his/her status as an owner/principal of a corporation shall be reviewed on a case by case basis for applicability under this section. Substantive shall be defined as either: 1) a dollar amount paid by the provider for compensatory damages within the ten year period in excess of $350,000.00, or 2) any determination of sexual misconduct, patient injury/negligence/unwarranted confinement, or administrative/professional misconduct.

B. The provider may not have any pending liability claims, settlements, or judgments of the substantive nature described in paragraph A above. (Provider status shall be suspended until the outcome is known.)

C. The provider may not have been denied or refused renewal of liability insurance, or had liability insurance involuntarily terminated, within the last ten years.

III. Miscellaneous

A. The provider may not, concurrent with his/her active practice, be in a rehabilitation program or other treatment for substance abuse. Any provider who has participated in such a program or treatment must have successfully done so at least four years prior to applying for network affiliation, and must have completed four subsequent continuous years of non-substance abuse status and be able to demonstrate

continued aftercare compliance (including random drug tests) for at least two years post-treatment. (Also refer to I.C. above.)

B. The provider may not suffer from any medical or mental condition which impairs his/her ability to practice.

C. The provider may not have any criminal record within the last ten years, nor have any criminal actions pending.

D. The provider may not have had membership in any professional organization revoked, suspended, or terminated involuntarily for any reason other than failure to pay membership fees, within the last ten years.

E. The provider may not have resigned from the staff of any hospital because of problems regarding privileges or credentials, nor had hospital privileges limited, suspended, revoked, or been denied renewal within the last ten years.

F. BHS reserves the right to terminate or refuse/reject any application for provider status after reasonable investigation by BHS in the event: 1) more than five patients complain to BHS regarding the provider, and/or any allegation of sexual misconduct is made by a BHS patient with respect to such provider; or 2) BHS receives such direction by one or more of its corporate clients; or 3) BHS learns of inappropriate or unprofessional conduct on the part of that provider.

G. The provider must have completed: 1) a BHS Treatment Provider Application and Certification, Authorization and Attestation; or 2) a state-approved Uniform Application, and BHS Treatment Provider Supplemental Application and Certification, Authorization and Attestation. The information contained in said application(s) must be true and complete, and any material misstatement, error, or omission in, said application(s) shall constitute cause for: 1) denial of said application(s); or 2) immediate termination of provider's participation in the network.

H. The BHS Credentialing Committee reserves the right to modify any of these requirements listed in this Section III. Miscellaneous on a case-by-case basis as determined appropriate.

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**