Criteria for Network Participation

Before completing the Practitioner Application, please review the following criteria required for network practitioners. Note: This check off sheet is provided for your convenience, please use to ensure you meet minimum criteria and to ensure your required materials are included with your completed application packet.

1. **Please review the applicable section for your discipline ONLY.**
2. **Check the criteria met in each box,**

PSYCHOLOGISTS

☐ Must possess Doctoral degree (PhD, EdD, PsyD) in clinical psychology or counseling psychology from an accredited college or university AND meet one of the following:

a. Doctorate was received from a college program on the American Psychological Association (APA) approved list of counseling psychology or clinical psychology programs **at the time of graduation OR**
b. Completion of a pre-doctoral APA approved clinical internship **at the time of graduation OR**
c. Listed in the National Register of Health Service Providers in Psychology **OR**
d. Be a diplomate with the American Board of Professional Psychology (ABPP) under the clinical psychology or counseling psychology categories.

Note: A **respecialization** in clinical psychology or counseling psychology is eligible with proof of completion of training.

☐ Licensed independently as a clinical psychologist at the highest level in the state where practice is to occur.

☐ Possess **professional liability coverage at a minimum level of $1,000,000 per episode and $3,000,000 aggregate.** Copy of current face sheet must be included (**must list applicant name as the insured, policy period and coverage amounts**).

SOCIAL WORKERS

☐ Must possess Master's degree or higher from a graduate school of social work accredited by the Council on Social Work Education (CSWE).

☐ State licensed or certified to practice at the highest level of *independent practice* in the state where practice is to occur.

☐ Possess **professional liability coverage at a minimum level of $1,000,000 per episode and $1,000,000 aggregate.** *Exceptions will be made in states where the maximum amount of coverage obtainable is less than the limits above.* Copy of current face sheet must be included (**must indicate applicant as the insured, policy period and coverage amounts**).

MASTER'S LEVEL COUNSELORS (LPC, LMFT, Psychological Examiners, Mental Health Counselors)

☐ Must possess Master's degree or higher in a mental health discipline from a regionally accredited college or university.

☐ State licensed or certified to practice independent y in the state where practice is to occur. Only acceptable in those states where clinical experience and exam requirements equal or exceed 2 years or 2,000 hours of clinical experience or 1,000 hours of direct clinical contact (face-to-face) or 100 hours of face-to-face supervision under an approved supervisor during the first two years of post-graduate direct clinical experience as defined by the appropriate state regulatory agency.

☐ Possess **professional liability coverage at a minimum level of $1,000,000 per episode and $3,000,000 aggregate**. Copy of current face sheet must be included (**must list applicant name as the insured, policy period and coverage amounts**).

Please Note: Practitioners have the right to review information submitted in support of their credentialing application. All requests for documentation must be submitted in writing. Advantage Behavioral Health will not release information obtained through the primary source verification process, when disclosure is prohibited by law. Advantage Behavioral Health also has the right to reject an application if they feel for any reason that the Applicant or Application will not be appropriate, beneficial or deemed unacceptable due to the law and/or any restrictions of their license(s).

APPLICATION and DOCUMENTATION CHECKLIST

For your convenience use the checklist below to prepare your Application for return.
To ensure timely processing, please enclose the required documents listed below in addition to your completed application.

RETURN:
Advantage Behavioral Health
44 Vantage Way, Suite 400
Nashville, TN 37228
Attention: Stephanie Shiers
PH: 615-463-6658 Fax: 615-460-4107

Checklist:

- ☐ **Completed and signed Practitioner Application**
- ☐ Completed FormW-9 Form for **each Tax Identification Number (TIN)** (original signature required) List only TIN or SSN – Do not enter both
- ☐ Current Professional Liability Face sheet (**must indicate practitioner's name as the insured or supply letter of inclusion, policy period and coverage amounts) A minimum level of $1,000,000 per episode and $3,000,000** aggregate is required.
- ☐ Current State License/Certification with the current date (wall or wallet copy is fine). If your state no longer issues a new license, please send a letter on your letterhead indicating that, the license type, number, and the dates of issuance, and your current license expiration.
- ☐ Education Commission for Foreign Medical Graduates (ECFMG) Certificate (if applicable)
- ☐ Test of English as a Foreign Language (TOEFL) Certificate (if applicable)
- ☐ Work History/Curriculum Vitae/Resume (**must include month and year**). Any lapse in continuous employment/work history since graduation from your graduate degree program must be fully explained on a separate sheet.

Top Application Errors:

Please review the list below to ensure that you avoid the most common Application errors:

- **OMMITTING MM/YYYY on education and work history – must have month and year**
- **Not Explaining Gaps in Work History Greater than 60 days**

On behalf of the Credentialing Team, we sincerely appreciate your attention to detail!

PRACTITIONER APPLICATION

ALL HIGHLIGHTED AREAS IN THE APPLICATION MUST BE COMPLETED

A. PROVIDER INFORMATION - DEMOGRAPHICS:

Last Name	First Name	Middle Initial	☐ Male ☐ Female
Mailing Address Line 1	Mailing Address Line 2	**NPI Number**	
City / County	State / Zip	**Phone FAX Mail email** Preferred Contact Method (**Circle One**)	
Telephone (include area code)	FAX (include area code)	Highest School Degree	State License Type
Social Security Number **(REQUIRED)**	Tax Identification Number **(REQUIRED)**	Date of Birth **(REQUIRED)**	Place of Birth (City, State, Country) **(REQUIRED)**
Medicaid Number **(or state N/A)**	MEDICARE Number **(or state N/A)**	OFFICE Contact Name:	Office Contact Number:
Indicate any other name you may have used in the past (e.g., maiden name, etc.)	Internet E-mail address (if applicable)		

LICENSED DISCIPLINE: Indicate the discipline under which you are **LICENSED and/or CERTIFIED** at the highest level to practice independently.

- ☐ Psychologist
- ☐ Social Worker
- ☐ CAC, CADS, NCAC, LADC, etc.
- ☐ Licensed Professional Counselor/Mental Health Counselor
- ☐ Marriage & Family Therapist/Marriage Family & Child Counselor
- ☐ Pastoral Counselor
- ☐ Other (specify): _____

B. PRIMARY PRACTICE INFORMATION

If Multiple Service Locations enter other locations(s) below under "Other Practice Locations".

Practice Name				
Practice Address Line 1 (street address required for referral purposes)		Practice Address Line 2		
City	County	State	Zip	Appointment Telephone (include area code)
Office Manager (if applicable)		Fax Number		

Make checks payable to (must match tax ID owner name on file with IRS for the TIN provided)			
Billing Address Line 1	Billing Address Line 2		
City / County	State / Zip	Telephone (include area code)	
Tax Identification Number (TIN) ***Must submit a substitute W-9 form for each tax ID used***	Your Medicare/UPIN Number	Your Medicaid Number	

Hours of Operation (actual practice hours each day at this location, e.g., **8:00am to 4:30pm**):

Monday		Tuesday		Wednesday		Thursday		Friday		Saturday	
From	To	From	To	From	To	From	To	From	To	From	To

Is this office handicapped accessible? ☒ Yes ☐ No **Is this office accessible to public transportation?** ☒ Yes ☐ No

Other Practice Location(s)

*(If you have **more than two** practice locations **copy this page before completing**)*

Practice Name				
Practice Address Line 1 (street address required for referral purposes)		Practice Address Line 2		
City	County	State	Zip	Appointment Telephone (include area code)
Office Manager (if applicable)		Fax Number		

Make checks payable to (must match tax ID owner name on file with IRS for the TIN listed below)				
Billing Address Line 1		Billing Address Line 2		
City	County	State	Zip	Telephone (include area code)
Tax Identification Number (TIN) ***Must submit a substitute W-9 form for each tax ID used***		Your Medicare/UPIN Number		Your Medicaid Number

Hours of Operation (actual practice hours each day at this location, e.g., **8:00am to 4:30pm**):

Monday		Tuesday		Wednesday		Thursday		Friday		Saturday	
From	To	From	To	From	To	From	To	From	To	From	To

Is this office handicapped accessible? ☐ Yes ☐ No **Is this office accessible to public transportation?** ☐ Yes ☐ No

Answering Service: Indicate how you can be reached after hours.

Answering Service Name	Phone #:
Pager or Beeper #	Voice Mail #

BILLING INFORMATION:

1. Does your office have electronic billing capacity? ☐ Yes ☐ No

   If yes, check one or more of the following:

   ☐ Software Vendor List software: _____ _____

   ☐ Claims Clearinghouses List vendor: _____

   ☐ Billing Service List vendor: _____

2. I will be signing my own claim forms. ☐ Yes ☐ No

3. I belong to an incorporated group/professional association. ☐ Yes ☐ No

   If yes, my affiliation with incorporated group/professional association began on _____ (date).

C. REFERRAL INFORMATION – NOTE % of Practice should equal 100%

Identify the percentage of your practice dedicated to the following patient population categories (must total 100%):

Population	% of Practice	Are You Currently Accepting New Patients?
Young Child (0-5) (YC)		⇒ ☐ Yes ☐ No
Child (6-12) (CI)		⇒ ☐ Yes ☐ No
Adolescent (13–17) (AO)		⇒ ☐ Yes ☐ No
Adult (18-64) (AU)		⇒ ☐ Yes ☐ No
Geriatric (65+) (GT)		⇒ ☐ Yes ☐ No

Modality	% of Practice
Inpatient	
Day Treatment	
Outpatient	
Intensive Outpatient Programs	

Identify any foreign language(s) or sign language that you use fluently in treating patients (select no more than 5):

☐ American Sign Language ☐ French ☐ Italian ☐ Russian
☐ Arabic ☐ German ☐ Japanese ☐ Spanish
☐ Armenian ☐ Greek ☐ Korean ☐ Swedish
☐ Chinese ☐ Hebrew ☐ Norwegian ☐ Tagalog/Filipino
☐ Dutch ☐ Hindi ☐ Polish ☐ Vietnamese
☐ Farsi ☐ Hungarian ☐ Portuguese ☐ Yiddish
☐ Other: _____

CLINICAL EXPERTISE (SPECIALTIES):

From the list below, **select the top five (5) specialty areas** for which you have training and expertise. These specialties will be used in making clinically appropriate referrals.

☐ Addictions, Non-Chemical
☐ Anger Management
☐ Alcohol / Chemical Dependency
☐ Childhood Behavioral Problems / Attention Deficit Hyperactivity Disorder (ADHD)/School-related problems
☐ Chronic Pain/Terminal Illness / Grief
☐ Disability Treatment
☐ Dissociative Identity Disorders
☐ Eating Disorders
☐ Faith Based
☐ Family Violence
☐ Gay/Lesbian/Bisexual Issues
☐ Head Trauma
☐ Hearing Impaired
☐ HIV / AIDS
☐ Marital/Separation/Divorce
☐ Men's Issues
☐ Military Families
☐ Obsessive Compulsive Disorder
☐ Personality Disorders
☐ Post Traumatic Stress Disorder
☐ Post Traumatic Stress Disorder (Combat)
☐ Severe & Persistent Mental Illness
☐ Sex Abuse Perpetrators
☐ Sex Abuse Victims
☐ Sexual Dysfunction
☐ Sleep Disorders
☐ Women's Issues

THERAPEUTIC MODALITIES:

From the list below, **select all areas** that you use when treating patients. These modalities will be used to assist in making clinically appropriate referrals.

☐ Brief Therapy , EAP
☐ Child/Adolescent Therapy
☐ Family Therapy
☐ Group Therapy
☐ CISM
☐ EAP, Workplace Issues
☐ EMDR
☐ IOP
☐ Neuropsych Testing
☐ Psych Testing
☐ Psychopharmacology
☐ CBT

Other:_____

SERVICES OFFERED: Please indicate if you provide services in any of the following areas.

☐ Case management services Specify: _____
☐ Emergency assessment and counseling *(Contact patient by telephone within 45 minutes)*
☐ In home care
☐ Suicide assessment/intervention *(Contact patient by telephone immediately)*
☐ Urgent/crisis intervention services
☐ Mandatory Prescreener (MPS)
☐ Department Of Transportation Substance Abuse Professional

D. EDUCATIONAL INFORMATION: (REQUIRED for verification purposes – MM/YYYY REQUIRED)

Cannot use your Resume or CV. **Months and Years**

Educational Institution (include name and complete address)		Degree	From (mm/yyyy)	To (mm/yyyy)
Undergraduate	Institution: Address: City, State, Zip:			
Graduate/ Medical School	Institution: Address: City, State, Zip:			
Internship	Institution: Address: City, State, Zip:			
Residency	Institution: Address: City, State, Zip:			
Fellowship	Institution: Address: City, State, Zip:			

E. ECFMG:

If you are a foreign medical school graduate, are you certified by the Educational Commission for Foreign Medical Graduates (ECFMG)? **If the answer is yes, please include a copy of your certificate.** ☐ Yes ☐ No

F. LICENSURE AND CERTIFICATIONS:

1. PROFESSIONAL LICENSE(S):

LIST ALL health care licenses held in the past ten (10) years. Indicate original licensure date through current expiration date for each state in which you are or have been licensed/certified.

An explanation is REQUIRED for any license that is no longer current, whether by voluntary relinquishment or disciplinary or other action. Attach an additional sheet if necessary.

Licensing Board Name	State	Specify Active or Inactive	Certificate #	Original Issue Date (mm/dd/yy)	Expiration Date (mm/dd/yy)
				/ /	/ /
				/ /	/ /

2. BOARD CERTIFICATION/SPECIALTY:

List below any certifications you have received from any nationally recognized specialty boards.

PRINCIPAL SPECIALTY Name of Board (if board certified)

Exam Information (check one):

☐ Oral exam taken ☐ Oral exam scheduled ☐ Written exam taken ☐ Written exam scheduled ☐ No plans to take

Exam Date: / / Date Certified: / / Expiration Date: / /

SECONDARY SPECIALTY Name of Board (if board certified)

Exam Information (check one):

☐ Oral exam taken ☐ Oral exam scheduled ☐ Written exam taken ☐ Written exam scheduled ☐ No plans to take

Exam Date: / / Date Certified: / / Expiration Date: / /

3. ADDITIONAL CERTIFICATIONS:

Certification Type	Certificate #	Expiration Date (mm/dd/yy)
Certified Employee Assistance Professional (CEAP)		/ /
Chemical Dependency Certification (Specify:_____)		/ /

Please include a current copy of your certification with your application materials.

5. MILITARY EXPERTISE: Are you a Military Veteran? ☐ Yes ☐ No If yes, please provide details below:

_____

_____

Have you had a close family member in the Military? ☐ Yes ☐ No If yes, please provide details below:

_____

_____

Please provide details below of any training or expertise related to serving military families.

_____

_____

_____

_____

_____

_____

_____

Are you a Star Trained Provider? ☐ Yes ☐ No If yes, please provide tiers completed below:

G. MALPRACTICE INSURANCE:

Enclose a copy of your current policy certificate and/or declarations page indicating you as the covered clinician, and showing the coverage limits and dates of coverage. A minimum level of $1,000,000 per episode and $3,000,000 aggregate is required.

➲ **ALSO, "LIST BELOW" your current malpractice carrier. Please DO NOT mark "See Policy".**

Current Carrier (Name and Certificate Number)	**Dates of Coverage**	**Coverage Limits**

➲ **Has the same carrier covered you for the past five (5) years?** ☐ Yes ☐ No If NO, see below.

If you have not been covered by the same carrier for the past 5 years, list below the name and complete address of any other malpractice carrier who has provided coverage for you for the most recent five (5) year period.
If there has been more than one carrier, please indicate the dates of coverage with each carrier, and the reason for changing carriers.

Carrier (Name and Complete Address)	**Dates of Coverage**	**Reason for Changing Carriers**

➲ **MALPRACTICE CLAIMS: Please provide information on pending and/or settled malpractice claims. A separate sheet maybe included if necessary.**

If NO CLAIMS, mark NA and advance to Section I. ☐ **NA** ****Check here if NA.**

Be as specific as possible with regard to procedures, names, dates, and actions. Explanations provided on pending and/or settled malpractice claims must include the minimum information requested below (you may use the space below, or include a separate sheet if necessary).

Patient's name:		Date of occurrence (mm/dd/yy):
Insurance company defending your claim:		
Hospital name:		
Hospital address:		
Procedures performed:		
Co-defendants:		
Court trial? ☐ Yes ☐ No	Settlement out of court? ☐ Yes ☐ No	Date of settlement (mm/dd/yy):
Allegations:		
Claim settled for no payment on your behalf? ☐ Yes ☐ No		Claim is pending? ☐ Yes ☐ No
Amount in reserve by insurance company:		Total amount paid to claimant on your behalf:

Total amount paid to claimant for all defendants:

H. WORK HISTORY: IMPORTANT NOTES SEE BELOW.

You must include MM/YYYY (Months and Years) – Any Gaps in work history GREATER THAN 60 days must be explained.

➔ This section may be used to provide your work history.
A current Curriculum Vita (CV) may be submitted in lieu of completing this section mark SEE CV below.
The CV must specify month and year.

Either your CV or this document must include MM /YYYY (Months and Years) of all work experience to meet credentialing standards. Use an extra page if needed.
Any lapse in continuous employment for work history since graduation from your graduate degree program must be fully explained on a separate sheet.

From (Month/Year) required	To (Month/Year)	Name, Location and Description of Activities
Example: 10/2004	12/2005	Sample Practice LLC, Nashville, TN – Staff Psychologist

I. COMMERCIAL INSURANCE PANELS

Please check all commercial insurance panels with which you are currently paneled. (In formation will be used in making appropriate referrals for continuation of services following EAP services.)

- ☐ Aetna
- ☐ Anthem
- ☐ Blue Cross/ Blue Shield
- ☐ Cigna
- ☐ Humana
- ☐ Magellan Health Services
- ☐ Military One Source
- ☐ Tricare
- ☐ Value Options

Others:_____

_____

_____

J. PROVIDER PROFILE: Please answer ALL provider profile questions. Each box must be addressed.

NOTE: If "**YES**" is checked, **please explain fully** on a separate sheet. **If NA, mark NA.**

Documentation is required if you have malpractice claims pending or settled, court charges (plead guilty or not) in the past five (5) years (include any settlements/adjudications, original complaint and final disposition). The documentation must be from an attorney or the entity that issued the judgment.

1. **Health Status:** Do you have any physical, mental, or emotional condition, including but not limited to any history of drug or alcohol abuse, which currently impairs your ability to render the professional services which are the subject of this application? "Currently" means recently enough so that the condition could reasonably have an impact on your ability to safely and competently render the professional services which are the subject of this application……	☐ Yes ☐ No
2. **Insurance Coverage:** Has your professional liability insurance coverage ever been denied, canceled, or non-renewed or initially refused upon application?.....	☐ Yes ☐ No
3. **License:** Has your medical or professional license in any state ever been revoked, suspended, placed on probation, conditional status, or limited?.....	☐ Yes ☐ No
a. Have you ever voluntarily surrendered your license?.....	☐ Yes ☐ No
b. Are formal charges pending against you at this time?	☐ Yes ☐ No
4. **Professional Membership(s):** Has your membership in any professional society or association ever been canceled, revoked, or censured?.....	☐ Yes ☐ No
5. **Medicare/Medicaid/TRICARE:** Have you ever been fined, had an arrangement suspended, been expelled from participation or had criminal charges brought against you by any Medicare, Medicaid or TRICARE program?.....	☐ Yes ☐ No
6. **Criminal Offenses:** Have you ever been arrested, charged with or convicted of a felony. ……	☐ Yes ☐ No
a. Have you ever arrested, charged with or convicted of a felony involved in charges relating to moral or ethical turpitude, including crimes with children?……	
b. Have you ever been named as a defendant in any criminal proceeding?.....	☐ Yes ☐ No
7. **Board Discipline:** Have you ever been the subject of disciplinary proceedings by any professional association or organization (i.e., state licensing board; county, state or national professional society; hospital medical or clinical staff)?.....	☐ Yes ☐ No
8. **Malpractice Action:** Has any malpractice action against you been brought or settled in the past 5 years or has there been any unfavorable judgment (s) against you in a malpractice action?.....	☐ Yes ☐ No
9. To your knowledge, is any malpractice action against you currently pending?.....	☐ Yes ☐ No
10. Please give a number of malpractice claims pending **and closed**: **CHECK "0" if NO CLAIMS** ☐ None (0) ☐ One (1) ☐ Two (2) ☐ More than 2 (please give number:_____)	**Please check one box – do not leave blank.**
13. Have you ever been a defendant in any lawsuit involving your practice where there has been an award or payment of $50,000 or more?……	☐ Yes ☐ No
15. Have you had any malpractice claims where there has been an award or payment of $50,000 or more?.....	☐ Yes ☐ No

PROVIDER ATTESTATION STATEMENT

Signature and Date Required

This credentialing information and the attached documents contain detailed and specific information relating to my character and professional competence. I warrant that all of the information that I have provided and the responses that I have given are correct and complete to the best of my knowledge and belief. I understand that willful falsification or willful omission of this information will be grounds for rejection or termination.

I understand that this application does not entitle me to participation in the Advantage Behavioral Health Network

I release Advantage Behavioral Health(Advantage), its representatives, and any individuals or entities providing information to Advantage from liability for any act or omission related to the evaluation or verification contained in this application provided Advantage, its representatives and individuals providing information to Advantage act in good faith and without malice. I further agree to notify Advantage of any change to the information provided in this application within 30 days of any such change. I understand that any information provided in this application that is not publicly available will be treated as confidential by Advantage.

In addition to any notice required by any contract with a Healthcare Organization, I agree to notify Advantage immediately in writing of the occurrence of any of the following: (i) the unstayed suspension, revocation, limitation, restriction or nonrenewal of my license to practice in any state; or (ii) any cancellation, limitation, restriction or nonrenewal of my professional liability insurance coverage.

I further agree to notify Advantage in writing, promptly and no later than fourteen (14) calendar days from the occurrence of any of the following: (i) receipt of written notice of any adverse action against me by the applicable State Regulation and Licensing or the applicable State Medical Examining Board taken or pending, including but not limited to, any accusation filed, temporary restraining order, or imposition of any interim suspension, probation or limitations affecting my license to practice medicine; or (ii) any adverse action against me by any Healthcare Organization which has resulted in the filing of a report with the applicable State Regulation and Licensing or the applicable State Medical Examining Board, or a report with the National Practitioner Data Bank; or (iii) the denial, revocation, suspension, reduction, restriction, limitation, nonrenewal or voluntary relinquishment by resignation of my medical staff membership or clinical privileges at any Healthcare Organization; or (iv) any material reduction in my professional liability insurance coverage; or (v) my receipt of written notice of any legal action against me, including, without limitation, any filed and served malpractice suit or arbitration action; or (vi) my conviction of any crime (excluding minor traffic violations); or (vii) my receipt of written notice of any adverse action against me under the Medicare or Medicaid programs, including, but not limited to, fraud and abuse proceedings or convictions.

I authorize Advantage Behavioral Health and its agents and any individual or entity providing information to Advantage to investigate and evaluate my provider application, and consult with any person, organization, or entity that has, or could have any information, data, or documents regarding my background, competence, and credentials.

_____ **Date (mm/dd/yy)** _____

Provider Signature *(Sign in script/cursive)*

_____ _____

Name (Please Print) **Degree**

RETURN COMPLETED APPLICATION TO:

Attention: Stephanie Shiers
Advantage Behavioral Health
44 Vantage Way, Suite 400
Nashville, TN 37228
Ph: 615-463-6658 Fax: 615-460-4107