Advantage
BEHAVIORAL HEALTH

APPLICATION and DOCUMENTATION CHECKLIST

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

Checklist:

- ☐ **Completed and signed Re-Credentialing Application and Attestation**
- ☐ Current Professional Liability Face sheet. **Must indicate practitioner's name as the insured, policy period and coverage amounts (Minimum of 1-3 Million).**
- ☐ Current State License/Certification
- ☐ Current Curriculum Vitae
- ☐ Proof of Board Certification (if Board Certified)

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

RE-CREDENTIALING APPLICATION

ALL HIGHLIGHTED AREAS IN THE APPLICATION MUST BE COMPLETED

A. PROVIDER INFORMATION - DEMOGRAPHICS:

					☐ Male
Last Name	First Name	Middle Initial	☐ Female		
				Phone Fax Email	
Mailing Address Line 1		Mailing Address Line 2		Preferred Contact Method (circle one)	
City	County	State	Zip	**NPI**	
Telephone (include area code)	FAX (include area code)			**Tax ID Number (REQUIRED**	
Email Address	OFFICE Contact Name			Office Contact Number	

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

- ☐ Psychologist
- ☐ Clinical Social Worker
- ☐ Licensed Professional Counselor/Mental Health Counselor
- ☐ Marriage & Family Therapist/Marriage Family & Child Counselor
- ☐ Pastoral Counselor
- ☐ Other (specify): ______________________________

** PLEASE ATTACH COPIES OF ALL CURRENT STATE LICENSES

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

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 language(s) or sign language that you use fluently in treating patients ____

CLINICAL EXPERTISE (SPECIALTIES):

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

☐ Addictions, Non-Chemical
☐ Eating Disorders
☐ Obsessive Compulsive Disorder
☐ Anger Management
☐ Faith Based
☐ Personality Disorders
☐ Alcohol / Chemical Dependency
☐ Family Violence
☐ Post Traumatic Stress Disorder

☐ Childhood Behavioral Problems / Attention
☐ Deficit Hyperactivity Disorder (ADHD)/School-related problems
☐ Chronic Pain/Terminal Illness / Grief
☐ Gay/Lesbian/Bisexual/Transgender Issues
☐ Post Traumatic Stress Disorder (Combat)
☐ Severe & Persistent Mental Illness
☐ Sex Abuse Perpetrators
☐ Sex Abuse Victims
☐ Chronic Illness/Pain/Disability
☐ Head Trauma

☐ Hearing Impaired
☐ HIV / AIDS
☐ Marital/Separation/Divorce
☐ Sexual Dysfunction
☐ Couples
☐ Men's Issues
☐ Sleep Disorders
☐ Dissociative Identity Disorders
☐ Military Families
☐ Women's Issues

THERAPEUTIC MODALITIES:

From the list below, **select up to four (4) modality 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
Other:____

☐ CISM
☐ EAP, Workplace Issues
☐ EMDR
☐ IOP

☐ Neuropsych Testing
☐ Psych Testing
☐ Psychopharmacology
☐ CBT

BOARD CERTIFICATION/SPECIALTY:

List below any certifications you have received from any nationally recognized specialty boards.
If NOT Applicable, mark NA and advance to Additional Certifications below. ☐ **NA**

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

Exam Date: / / Date Certified: / / Re-exam 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

Exam Date: / / Date Certified: / / Re-exam Date: / /

D. MALPRACTICE INSURANCE:

****Check here if NA.**

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.

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:		

E. 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)

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

Others:____

____

Please list any Trainings completed in the past 3 years

____

____

____

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

K. 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 <u>required</u> 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.

Question	Answer
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