Behavioral Health Provider Initial Credentialing Application

Please asnwer the questions as listed below. You will be able to save and resume your work at anytime by choosing the "save" button on the bottom right hand of the page. Please note you will need to fill out this form sequentially, page by page, and will be unable to skip forward to another page without finishing the page you are on.

General Information

Are you fully licensed to practice independently as a clinical provider?
⦿ Yes ○ No

Section 1: General Information

Name

First | MI | Last

Gender
○ Male ○ Female ○ Other

Name on W-9, if different

Tax ID/EIN

Social Security Number

NPI

Provider Direct Email

Email of person completing this form, if different

Website, if applicable

Do you offer faith-based counseling?
⦿ Yes ○ No

Which faith:

Do you offer video counseling (tele behavioral health) to your clients?
○ Yes ○ No
⦿

Would you be interested in additional opportunities for you to receive referrals from other networks?
○ Yes ○ No
⦿

Are you registered with CAQH, formerly the Universal Provider Datasource?

○ Yes ○ No

Thank you for answering, as we are exploring using CAQH in the future. We currently do not accept CAQH in lieu of this application.

Locations & Addresses

Section 2: Locations and Addresses

Please enter an individual address for each physical location, as well as mailing addresses as needed.

Please enter information below:

Location/Address 1

Address

Address Line 1

Address Line 2

City | State | Zip Code

County:

Phone | **Extension** | **Fax**

Location Point of Contact | **Location Point of Contact Email**

Please list below the hours you maintain in this location, in general:

Monday | **Tuesday** | **Wednesday** | **Thursday** | **Friday**

Saturday | **Sunday**

During office hours, who answers the telephone at this location?
○ Office Staff ○ Voicemail ○ Answering Service
⊙

After office hours, who answers the telephone at this location?
○ Office Staff ○ Voicemail ○ Answering Service
⊙

For urgent needs, are you normally able to schedule clients within 24 hours at this location?
○ Yes ○ No
⊙

Can you normally offer routine appointments within 3 business days at this location?
○ Yes ○ No
⊙

Please check all that apply to this location:
☐ This location is also a personal residence.

☐ This location complies with Americians with Disability Act (ADA) Regulations.

☐ This location is accessible by public transportation.

Are the physical and mailing address for this location the same?

○ Yes ⊙ No

Mailing address if different from physical address

Address Line 1

Address Line 2

City | State | Zip Code

Current Licensure

Section 3: Current Individual License/Certification Practice History

Please upload your current CV or resume here:

Is there a 6 month or more gap in your practice/employment history?

⦿ Yes ○ No

○

Please explain the reason for the gap(s):

Date Began Fully Licensed Practice

Years In Practice

Use "1" for the day if you know the month and year, yet not the date.

Do you have a clinical supervisor?

⦿ Yes ○ No

Clinical Supervisor Name, Title:

Licensure

Please list all active state licenses and certifications individually.

License 1

State	License Type	License/Certification Number	Exp. Date

Please upload a copy of your current State License here:

Education

Please list each degree separately.

School Information 1

Degree **College/University Name**

○ Bachelors ○ Masters ○ Doctorate

⊙

Date Completed

College and University Location

City

State

Please upload a copy of your College/University degree here:

Clinical Affiliations

Section 4: Clinical Affiliations/Privileges

Do you have any facility privileges?
⊙ Yes ○ No

Facility Privileges

Includes hospitals, substance abuse rehabilitation, nursing homes, etc.

Facility 1

Facility Name

Staff Status
⊙ Active ○ Pending ○ Expired
○

Facility Address

Address Line 1

Address Line 2

City | State | Zip Code

Privileges

List all with commas

Professional Liability

Section 5: Professional Liability Information

Current Insurance

Note: BPA Health requires you carry $1,000,000/$3,000,000 Liability Coverage. If you do not have this amount in coverage, you will need to secure it before continuing with your application.

Insurer Name

Policy Expiration Date

Policy Number

Limits of Liability Per Occurance

Limits of Liability Per Aggregate

Please upload a copy of your current Certificate of Malpractice Insurance here:

Have you been with this insurer more than 5 years?

○ Yes ⊙ No

If you have not been in practice 5 years, select "Yes"

Previous Insurer

Must cover the past 5 years.

Previous Insurer 1

Previous Insurer Name

Policy Expiration Date

Policy Number

Limits of Liability Per Occurance

Limits of Liability Per Aggregate

Please upload a copy of your prior Certificate of Malpractice Insurance here:

Specialty Attestation

Section 6: Specialty Attestation

Please check all that apply.

Populations

- ☐ Adults (18+)
- ☐ Adolescents (13-17)
- ☐ Children (6-12)
- ☐ Preschool (0-5)
- ☐ Geriatrics (60+)
- ☐ Couples/Marriage
- ☐ Family
- ☐ Veterans/Military Families
- ☐ Gay/Lesbian/Bisexual/Transgender
- ☐ Hearing Impaired
- ☐ Gender Specific, Male
- ☐ Gender Specific, Female

Clinical Expertise

- ☐ Adoption
- ☐ Anger Management
- ☐ Grief/Bereavement
- ☐ Trauma
- ☐ Weight Loss
- ☐ Smoking Cessation
- ☐ Play Therapy
- ☐ Borderline
- ☐ Dual Diagnosis:Mental Health/Substance Abuse
- ☐ Mandatory Referrals
- ☐ Workshops, Trainings, & Health Fairs
- ☐ TBI (Traumatic Brain Injury)
- ☐ Financial & Legal
- ☐

Group Therapy

- ☐ PTSD
- ☐ Anger Management
- ☐ Domestic Violence
- ☐ Sexual Abuse
- ☐ Depression
- ☐

Addictions

- ☐ Substance Use Disorders
- ☐ Gambling
- ☐ Sex
- ☐

Medical

- ☐ Biofeedback
- ☐ Pain Management
- ☐ Medical Conditions
- ☐ Developmental Disabilities
- ☐ Neuro-Psychological
- ☐ Psychological Testing
- ☐ Medication Management
- ☐

Disorders

- ☐ ADHD
- ☐ Adjustment
- ☐ Eating:Anorexia/Bulimia
- ☐ Panic
- ☐ Personality
- ☐ Mood
- ☐ OCD
- ☐ Autism Spectrum
- ☐ Anxiety
- ☐ Psychotic
- ☐ Phobias
- ☐ Organic/Cognitive
- ☐ PTSD
- ☐ Conduct Issues
- ☐ Bipolar
- ☐ Oppositional Defiant

☐ Sleep ☐ Sexual
☐ Dementia ☐ Somatoform
☐ Substance Use ☐ Impulse Control
☐

Certifications
☐ SAP (Substance Abuse Professional)
☐ CIR (Critical Incident Response)
☐ Meditation
☐ EMDR
☐ Addiction
☐ Hypnosis
☐

Victims/Offenders
☐ Domestic Violence Offenders
☐ Domestic Violence Victims
☐ Sexual Offenders
☐ Sexual Victims
☐ Offender Re-entry Low Risk
☐ Offender Re-entry High-Risk
☐ Sexual Harassment (Work Place)
☐

Languages, in which you are fluent, beyond English:
☐ Spanish ☐ French ☐ German ☐ American Sign
☐ Will work with interpreter
☐

Critical Incident Response (for employer and work group situations, such as an employee death). Are you able to provide a CIR if your schedule allows?
○ Yes ○ No
⊙

Please upload Professional Accreditations or Certifications here:
You may upload up to 20 documents with this link.

Action History

Section 7: Action History

Licensure

Has your license, registration or certification to practice in your profession, ever been voluntarily or involuntarily relinquished, denied, suspended, revoked, restricted, or have you ever been subject to a fine, reprimand, consent order, probation or any conditions or limitations by any state or professional licensing, registration or certification board?
○ Yes ○ No

Has there been any challenge to your licensure, registration or certification?
○ Yes ○ No

Hospital Privileges and Other Affiliations

Have your clinical privileges or medical staff membership at any hospital or healthcare institution, voluntarily or involuntarily, ever been denied, suspended, revoked, restricted, denied renewal or subject to probationary or to other disciplinary conditions (for reasons other than non-completion of medical record when quality of care was not adversely affected) or have proceedings toward any of those ends been instituted or recommended by any hospital or healthcare institution, medical staff or committee, or governing board?
○ Yes ○ No

Have you voluntarily or involuntarily surrendered, limited your privileges or not reapplied for privileges while under investigation?
○ Yes ○ No

Have you ever been terminated for cause or not renewed for cause from participation, or been subject to any disciplinary action, by any managed care organizations (including HMO's, PPO's, or provider organizations such as IPA's, PHO's)?
○ Yes ○ No

Education, Training, and Board Certification

Were you ever placed on probation, disciplined, formally reprimanded, suspended or asked to resign during internship, residency, fellowship or other clinical education program? If you are currently in a training program, have you been placed on probation, disciplined, formally reprimanded, suspended or asked to resign?
○ Yes ○ No

Have you ever, while under investigation or to avoid an investigation, voluntarily withdrawn or prematurely terminated your status as a student or employee in any internship, residency, fellowship or other clinical education program?
○ Yes ○ No

Have any of your board certifications or eligibility ever been revoked?
○ Yes ○ No

Have you ever chosen not to re-certify or voluntarily surrendered your board certification(s) while under investigation?
○ Yes ○ No

Medicare, Medicaid, or Other Governmental Program Participation

Have you ever been disciplined, excluded from, debarred, suspended, reprimanded, sanctioned, censured, disqualified or otherwise restricted in regard to participation in the Medicare or Medicaid program, or in regard to other federal or state governmental healthcare plans or programs?
○ Yes ○ No

Other Sanctions or Investigations

Are you currently the subject of an investigation by any hospital, licensing authority, DEA or CDS authorizing entities, education or training program, Medicare or Medicaid program, or any other private, federal or state health program or a defendant in any civil action that is reasonably related to your qualifications, competence, functions, or duties as a medical professional for alleged fraud, an act of violence, child abuse or a sexual offense or sexual misconduct?
○ Yes ○ No

To your knowledge, has information pertaining to you ever been reported to the National Provider Data Bank or Healthcare Integrity and Protection Data Bank?
○ Yes ○ No

Have you ever received sanctions from or are you currently the subject of investigation by any regulatory agencies (e.g., CLIA, OSHA, etc.)?
○ Yes ○ No

Have you ever been convicted of, pled guilty to, pled nolo contendere to, sanctioned, reprimanded, restricted, disciplined or resigned in exchange for no investigation or adverse action within the last ten years for sexual harassment or other illegal misconduct?
○ Yes ○ No

Professional Liability Insurance Information and Claims History

Has your professional liability coverage ever been cancelled, restricted, declined or not renewed by the carrier based on your individual liability history?
○ Yes ○ No

Have you ever been assessed a surcharge, or rated in a high-risk class for your specialty, by your professional liability insurance carrier, based on your individual liability history?
○ Yes ○ No

Malpractice Claims History

Have you had any professional liability actions (pending, settled, mediated or litigated) within the past ten years? If yes, provide information for each case.
○ Yes ○ No

Criminal/Civil History

Note: A Criminal record will not necessarily be a bar to acceptance.

Have you ever been convicted of, pled guilty to, or pled nolo contendere to any felony?
○ Yes ○ No

In the past ten years have you been convicted of, pled guilty to, or pled nolo contendere to any misdemeanor (excluding minor traffic violations) or been found liable or responsible for any civil offense that is reasonably related to your qualifications, competence, functions, or duties as a medical professional, or for fraud, an act of violence, child abuse or a sexual offense or sexual misconduct?
○ Yes ○ No

Ability to Perform Job

Are you currently engaged in the illegal use of drugs?
○ Yes ○ No

Do you use any chemical substances that would in any way impair or limit your ability to practice and perform the functions of your job with reasonable skill and safety?
○ Yes ○ No

Do you have any reason to believe that you would pose a risk to the safety or wellbeing of your patients?
○ Yes ○ No

Are you unable to perform the essential functions of a practitioner in your area of practice even with reasonable accommodation?
○ Yes ○ No

Release & Signature

Section 8: Release & Signature

RELEASE OF INFORMATION/LIABLITY

As part of the application process and for the purpose of verifying any information provided on this application, I grant BPA Health and its designated representatives permission to contact any individual, institution, facility or agency identified on, or relative to, this application. Further, I hereby consent and authorize BPA Health to request, receive, inspect and release any and all information pertinent to consideration of this application to other insurance companies for whom BPA Health performs delegated credentialing.

I hereby release from any liability and hold harmless BPA Health and all individuals and organizations who provide BPA Health and its designated representatives with information – including otherwise privileged or confidential information – concerning my competence, professional ethics, character, physical and mental health, emotional stability, and other qualifications pertinent to BPA Health's needs.

SITE REVIEW AUTHORIZATION:
I hereby grant permission for BPA Health or its designee to conduct on-site and clinical record review of clients managed by BPA Health as necessary to determine their quality and completeness. I further agree that I will participate in and support BPA Health's Quality Improvement and Utilization Review Programs.

ATTESTATION:
I, the undersigned applicant, hereby attest and certify that to the best of my knowledge, I am free of any physical and mental health impairments and impairment due to chemical dependency or substance abuse that would adversely affect my ability to deliver the care expected of my profession.

I also attest and certify that this application has been completed truthfully and accurately. I understand that falsification of information on this application or substantial error of fact involving documents discovered can be grounds for termination of present and/or future contracts with BPA Health.

Further, I understand that acceptance of this application does not constitute approval or acceptance of participating status with BPA Health and grants me no rights or privileges of participation until such time as a contract is signed and written notice of participating status is received.

I acknowledge that action on this application will be delayed until all required information is received and/or verified.

A photocopy of this document will serve as the original. I understand that BPA Health or its designee will use this information in confidence and only in conjunction with this application.

Please type in your name if you agree to the Release of Information/Liability

In agreement with the Release of Information/Liability, and hereby submitting your completed application, please sign and date below:

Are you submitting this application on your own behalf as the fully licensed Provider?
○ Yes ○ No

Direct Deposit Authorization

Authorization Agreement for Automatic Deposits (Credits)

I/we hereby authorize BPA Health, hereinafter called COMPANY, to initiate credit entries to our Checking/Transaction Account indicated below and the depository named below, hereinafter called DEPOSITORY, to credit the same to such account. I/we acknowledge that the origination of ACH transactions to my/our account must comply with the provisions of U.S. law.

Depository Name

Transit/Routing Number

Account Number

Please Upload a Scanned Voided Check

This authorization is to remain in full force and effect until COMPANY has received written notification from me/us of its termination in such time and in such manner as to afford COMPANY and DEPOSITORY a reasonable opportunity to act on it. I/We understand that thirty (30) days notice, in writing, to the COMPANY is required if we change banks and/or accounts.

Signature

Date

Title