United Healthcare Community Plan

Organizational Provider Application

(Facility/Community Mental Health Center)

Tennessee Medicaid (TennCare)

Is the organizational provider currently in the UnitedHealthcare Community Plan TennCare network?	☐ Yes ☐ No

Acceptance into the UnitedHealthcare Community Plan ("UHCCP") provider network is contingent upon the applicant organizational provider meeting our credentialing standards and being approved by the Credentialing Committee. We collect updated documentation in order to recredential organizational providers approximately every 36 months. The requested information is required in order to comply with UHCCP credentialing standards and continue your participation in the network.

Organizational Provider Identifying Information

Legal Name of Facility _____

Parent Company/Health System Name (if applicable) _____

DBA (Identifying) Name _____

Administrative Address _____

City, State, Zip _____ County _____

Administrative Phone _____ Fax _____ Email _____

Website _____

Tax Identification Number _____

National Provider Identifier (NPI) Primary _____ Secondary _____

Billing/Remit Address _____

City, State, Zip _____

Identify Levels of Care Organizational Provider Desires to Contract

Psychiatric / Mental Health	**Adult**	**Geriatric**	**Adolescent**	**Child**
I/P Locked	☐	☐	☐	☐
I/P Open	☐	☐	☐	☐
Residential	☐	☐	☐	☐
Health Link	☐	☐	☐	☐
Supportive Community Living	☐	☐	☐	☐
Supportive Housing	☐	☐	☐	☐
Enhanced Supportive Housing (Medically Fragile)	☐	☐	☐	☐
Comprehensive Child & Family Treatment (CCFT)	☐	☐	☐	☐
Continuous Treatment Team (CTT)	☐	☐	☐	☐
Program of Assertive Community Treatment (PACT)	☐	☐	☐	☐
Psychosocial Rehab Individual and/or Group	☐	☐	☐	☐
Peer Support Individual and/or Group	☐	☐	☐	☐
Illness Management Recovery Individual and/or Group	☐	☐	☐	☐
Supported Employment	☐	☐	☐	☐
Partial Hospitalization	☐	☐	☐	☐
MH IOP	☐	☐	☐	☐
Crisis Services (i.e. stabilization, 23-hour Ob)	☐	☐	☐	☐
Other:	☐	☐	☐	☐
ECT	☐ Inpatient		☐ Outpatient	

Substance Use Disorder / Chemical Dependency	**Adult**	**Geriatric**	**Adolescent**
Medically Managed Intensive Inpatient Services ASAM 4 *Location: Acute care hospital only*	☐	☐	☐
Medically Monitored intensive Inpatient Services ASAM 3.7 WM *Location: Acute care or freestanding healthcare setting*	☐	☐	☐
Medically Monitored Intensive Inpatient Services (SUD Inpatient) ASAM 3.7 *Location: Acute care or freestanding healthcare setting*	☐	☐	☐
Clinically Managed High-Intensity Residential Services (SUD Residential) ASAM 3.5 *Location: Therapeutic Community; freestanding healthcare setting*	☐	☐	☐
Partial Hospitalization (PHP) – ASAM 2.5	☐	☐	☐
SUD Intensive Outpatient (IOP) – ASAM 2.1	☐	☐	☐

Substance Use Disorder / Chemical Dependency *(continued)*	Adult	Geriatric	Adolescent
Ambulatory Detox (Drug or Alcohol) – ASAM 1 WM	☐	☐	☐
Outpatient Clinic – ASAM 1	☐	☐	☐
Opioid Treatment Program	☐	☐	☐
Other:	☐	☐	☐

IDENTIFY PRACTICE LOCATION(S) ONLY FOR ABOVE CHECKED LEVELS OF CARE

Facility/Organizational Provider Location(s)	Age Category/ Population	Mental Health: Acute Inpatient	Residential	Partial Hospitalization	Intensive Outpatient	Case Management- CCFT,CTT	*Other	Substance Use Disorder: Medically Managed Intensive Inpatient Services ASAM 4	Medically Monitored Intensive Inpatient Services ASAM 3.7 WM	Medically Monitored Intensive Inpatient Svc. (SUD Inpatient) ASAM 3.7	Clinically Managed High-Intensity Residential Services (SUD Residential) ASAM 3.5	Partial Hospitalization ASAM 2.5	Intensive Outpatient ASAM 2.1	Ambulatory Detox (Drug or Alcohol) ASAM 1 WM	*Other
Location #1:															
	Adult	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	Geri	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	Adol	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Admission	Child	☐	☐	☐	☐	☐	☐								
Phone:		**# of IP Beds (MH):**						**# of IP Beds (SUD):**							
Secure Fax:		**# of Medicare Acute IP Beds (MH):**													
Location #2:															
	Adult	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	Geri	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	Adol	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Admission	Child	☐	☐	☐	☐	☐	☐								
Phone:		**# of IP Beds (MH):**						**# of IP Beds (SUD):**							
Secure Fax:		**# of Medicare Acute IP Beds (MH):**													
Location #3:															
	Adult	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	Geri	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	Adol	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Admission	Child	☐	☐	☐	☐	☐	☐								
Phone:		**# of IP Beds (MH):**						**# of IP Beds (SUD):**							
Secure Fax:		**# of Medicare Acute IP Beds (MH):**													

***If additional space is needed to add "Other" services, please print additional copies of this page and continue to insert services in the "Other" column.**

ORGANIZATIONAL PROVIDER CONTACT INFORMATION			
	Name	**Phone**	**E-mail Address**
Primary Contact			
Signatory Contact			
Facility Contracting Contact			
Administrator / Roster Contact			
Business Office Manager			
Director of Clinical Services			
Medical Director			
Chief Executive Officer			

ACCREDITATION			
	Issue Date	**Expiration Date**	**Not Applicable**
The Joint Commission			☐
Commission on Accreditation of Rehabilitation Facilities (CARF)			☐
American Osteopathic Association (AOA)			☐
Council on Accreditation (COA)			☐
Community Health Accreditation Program (CHAP)			☐
Center for Improvement in Healthcare Quality (CIHQ)			☐
American Association for Ambulatory Health Care (AAAHC)			☐
Critical Access Hospitals (CAH)			☐
Healthcare Facilities Accreditation Program (HFAP, through AOA)			☐
National Integrated Accreditation for Healthcare Organizations (NIAHO, through DNV Healthcare)			☐
Accreditation Commissions for Healthcare (ACHC)			☐
Please list other Accreditation held by your organization			

LICENSURE / CERTIFICATION (Participating Providers, only include for the Level(s) of Care being added to contract)				
	Entity Issuing License or Certification	**Type of License or Certificate**	**License Number**	**Expiration Date**
1.				
2.				
3.				
4.				

Does the Organizational provider state licensure/certification include a site visit by the State? ☐ Yes ☐ No

If "Yes", please attach a copy of the audit completed by the State with this application.

MEDICARE / MEDICAID / NPI / KEPRMEDICARE / MEDICAID/ NPI / KEPRO				
	Number	**Issue Date**	**Expiration Date**	**Not Applicable**
Medicare ID Number (6 digits) **(Must include Medicare # validation from CMS)**	Primary			☐
	Secondary			☐
Medicaid ID Number **(Must include Medicaid # validation from applicable state entity)**	Primary			☐
	Secondary			☐
National Provider Identifier (NPI)	Primary			☐
	Secondary			☐

GENERAL / PROFESSIONAL LIABILITY

Please attach current certificates for two types of liability insurance information. UnitedHealthcare insurance requirements are as follows:

For facilities/programs **with** an acute inpatient component:

Professional/general liability $5,000,000/$5,000,000 minimum coverage

For facilities/programs **without** an acute inpatient component:

Professional liability $1,000,000/$3,000,000 minimum

coverage Comprehensive general liability $1,000,000/$3,000,000 minimum

coverage

Professional Liability Limits: _____ **General Liability Limits:** _____

If you are self-insured, we require the portion of the facility's independently audited financial statement which shows retention of the required amounts stated above.

LEGAL STATUS

Has the Organizational Provider or any party owning or controlling 5% or more of your company have knowledge of or been subject to disciplinary action, criminal/ethical investigations or convictions, such as but not limited to revocation, suspension or restriction of its license; Medicare/Medicaid provider status; certification or accreditation status (i.e., The Joint Commission, P.R.O., CARF, COA, AOA, etc.); bankruptcy, insolvency or assignment of creditor proceedings?

☐ Yes * ☐ No

** If yes to the above, please attach a brief explanation for each incident.*

LOCATION ACCESSIBILITIES (please complete all conditions that apply)			
	Days	**Hours**	**Not Applicable**
Standard business operating hours			☐
Evening Hours (any hours after 5pm)			☐
Weekend Hours (Saturday or Sunday)			☐
TDD Capability			☐
Public Transportation Access			☐
Wheelchair/Handicap Accessibility			☐

SIGNATURE

I hereby certify that all of the responses and information provided pursuant in this application are complete, true and correct to the best of my knowledge and belief. I further warrant that facility's applicable licensure(s) is current and free of sanction or limitation. I understand that facility is responsible for adherence to UnitedHealthcare Community Plan credentialing plan, clinical guidelines, and other processes. I warrant that I have the authority to sign this application on behalf of the entity for which I am signing in representative capacity. I warrant that I (or my designee) have reviewed and will consistently review the level of care guidelines associated with services being credentialed. The level of care guidelines can be found at

uhccommunityplan.com/health-professionals/tn

Signature	Date
Name (please type or print)	**Title (please type or print)**

PREPARATION CHECKLIST

Please provide the following documents:

- ☐ Current State License(s)/ Certificate(s) for all behavioral health services you provide, i.e. psychiatric, substance abuse, residential, intensive outpatient, etc. A18 – include all documentation for multiple facility locations.
- ☐ Accreditation status (i.e. The Joint Commission, CARF, COA, etc.)
- ☐ Medicare or Medicaid certification letter with Medicare number **(REQUIRED** if applying for participation in Medicaid or Medicare networks)
- ☐ Program Description-including any specialty program descriptions and hours per day/ days per week
- ☐ Professional and General liability insurance certificates showing limits, policy number(s) and expiration date(s). If self -insured, attach a copy of an independently audited financial statement which shows retention of the required amounts.

Other Documents (Only needed for new facility applicants):

- ☐ W9 form: If multiple tax ID numbers used, one W9 must be submitted for each
- ☐ Staff Roster for all behavioral health staff involved with your programs. Please list their degrees, licenses and/or certificates. We do not need an actual copy of their licenses or certifications.
- ☐ Daily Program Schedule(s) – include an hour-by-hour schedule showing a patient's daily treatment for each level of care you provide. Include weekend scheduling, where appropriate,

Policies and Procedures (Only needed for new facility applicants):

- ☐ Policy and Procedure on Intake/Access Process to Behavioral Medicine
- ☐ Policy and Procedure on Intake/Access Process if done through E.R.
- ☐ Policy and Procedure on Holds/Restraints
- ☐ Policy and Procedure for Discharge Planning

Managed Care Participation

List the names of any managed care companies with whom you currently contract (including UnitedHealthcare):

1. _____ How Long? _____
2. _____ How Long? _____
3. _____ How Long? _____

Facility Type Information

Identify what best describes your organization.

MH	SUD		MH	SUD		MH	SUD	
☐	☐	Freestanding Day Treatment	☐	☐	Ambulatory Detox (Alcohol)	☐	☐	Rural Health Clinic
☐	☐	Center Freestanding IOP	☐	☐	General Acute Hospital with Detox	☐	☐	Outpatient Detox Center
☐	☐	General Acute Care Hospital	☐	☐	Psychiatric Residential Facility	☐	☐	SUD Recovery Home
☐	☐	Freestanding Psychiatric Hospital	☐	☐	Community Mental Health Center	☐	☐	SUD Rehabilitation Facility
☐	☐	Residential Treatment Center	☐	☐	Home Health Care Agency	☐	☐	SUD Residential Facility
☐	☐	Ambulatory Detox (Drug)	☐	☐	Facility Opioid Treatment Center	☐	☐	Other:

Staffing

Please answer the following questions relating to your professional psychiatry staff:

1. Are services by psychiatrists restricted to staff / faculty psychiatrists? ☐ Yes ☐ No
2. Number of board-certified psychiatrists on staff: _____
3. Indicate below the number of psychiatrist visits per week by level of care:

	IP Acute	Medically Managed Intensive Inpatient Services ASAM 4	Medically Monitored Intensive Inpatient Services ASAM 3.7 WM	SUD Inpatient ASAM 3.7	Clinically Managed High Intensity Residential Services (SUD Residential) ASAM 3.5	MH Residen-tial	Partial Hospital-ization ASAM 2.5	MH PHP	Intensive Outpatient Services ASAM 2.1	MH IOP
Number of visits by MD										
Number required in Facility bylaws or policy										

Compensation

Indicate your current retail rates and approximate discounted contracted rates for each level of care on a per diem basis, exclusive or inclusive of professional fees:

Mental Health		
Level of Care	**Retail**	**Discount**
IP Locked		
IP Acute		
Residential		
Full day Partial		
Intensive OP		
ECT – Outpatient		
ECT – Inpatient		

Substance Use Disorder/Chemical Dependency		
Level of Care	**Retail**	**Discount**
Medically Managed Intensive Inpatient Services ASAM 4		
Medically Monitored Intensive Inpatient Services ASAM 3.7 WM		
Medically Monitored Intensive Inpatient Services (SUD Inpatient) ASAM 3.7		
Clinically Managed High- Intensity Residential Services (SUD Residential) ASAM 3.5		
Full day Partial ASAM 2.5		
Intensive OP ASAM 2.1		
Ambulatory Detox ASAM 1 WM		

Please identify any other services that are provided by the facility/Community Mental Health Center with rate information:

Service Type	Retail Rate	Discount	Comments

Delivery of Care

Please answer the following questions relating to your policy and procedures as identified:

1. How often is individual therapy provided?
2. How often is family therapy provided?
3. What is the patient staff ratio?
4. What is the staff position responsible for discharge planning?
5. Describe your discharge planning procedures:
6. What percentage of patients are referred for follow up care?
7. What are your protocols for psych testing?
8. For the partial hospital and IOP services, does the program serve as a step down or are patients directly admitted?

   8.1 Does your Partial Hospital or IOP program align with ASAM, LOCUS, CASII, and/or ECSII, as applicable? ☐ Yes ☐ No
9. What percentage of patients are directly admitted to the partial and IOP programs?
10. What components are present in your Substance Use Disorder programs?
    - ☐ No SUD services offered
    - ☐ Education is directed to drug of choice
    - ☐ Relapse prevention is part of program
    - ☐ Program meets Department of Transportation requirements
    - ☐ There are criteria for drug/alcohol urine screens
11. Please identify your Average Length of Stay (ALOS) for each program

ALOS	Mental Health Services
	Locked
	Acute
	Residential
	Partial Hospitalization
	Intensive Outpatient

ALOS	Substance Use Disorder Services
	Medically Managed Intensive Inpatient Services (ASAM 4)
	Medically Monitored Intensive Inpatient Service (ASAM 3.7 WM)
	Medically Monitored Intensive Inpatient Svcs. (SUD Inpatient) (ASAM 3.7)
	Clinically Managed High-Intensity Residential Services (SUD Residential) (ASAM 3.5)
	Partial Hospitalization (ASAM 2.5)
	Intensive Outpatient (ASAM 2.1)
	Ambulatory Detox/Withdrawal Management Services (ASAM 1 WM)

12. Are there any programs/departments within the facility managed by external organizations? (i.e. emergency room, specialty programs) ☐ Yes ☐ No

If "Yes", please provide the following:

Facility Dept or Program	Organization Name	Address	Contact Name	Phone

Service Delivery / Specialty Services

1. **If Medically Managed Intensive Inpatient (ASAM 4) is offered at Facility, please identify, with a check mark, the physical location of beds:**

   ☐ Bed located on a medical floor/unit ☐ Bed located on a behavioral health unit

2. **If Facility offers partial hospitalization and/or Intensive Outpatient Programs, please indicate number of hours of treatment per day and how many days per week (please review clinical requirements at uhcprovider.com)**

   Partial Hospitalization Intensive Outpatient
3. **If Facility offers both ASAM 3.5 and ASAM 3.7, is Facility aware of the differences in the clinical requirements between the two levels of care?** ☐ Yes ☐ No

4. **Does Facility offer Medication Assisted Treatment (MAT) in the following levels of care?**

	Available	Not Available		Available	Not Available
Medically Monitored Intensive Inpatient Services ASAM 3.7 WM	☐	☐	PHP ASAM 2.5	☐	☐
Medically Monitored Intensive Inpatient Svcs. (SUD Inpatient) ASAM 3.7	☐	☐	IOP ASAM 2.1	☐	☐
Clinically Managed High-Intensity Residential Services (SUD Residential) ASAM 3.5	☐	☐	Ambulatory Detox ASAM 1	☐	☐

Medications: _____

5. **Please indicate if Facility is able to accommodate the following membership needs in your service area:**

	Available	Not Available	Accommodation Method
Member language needs	☐	☐	
Member handicap needs	☐	☐	

a. Are all locations handicapped accessible? ☐ Yes ☐ No

If "No", please indicate which locations would not meet the criteria for handicapped accessibility:

_____

6. **Identify specialty services offered:**

	Available	Not Available	Locations	Comments
Eating Disorder Treatment – Inpatient	☐	☐		
Electro-convulsive Therapy (ECT) - Inpatient	☐	☐		
Electro-convulsive Therapy (ECT) – Outpatient	☐	☐		
Dual Diagnosis Services	☐	☐		
Continuing Day Treatment	☐	☐		
LGBTQ services	☐	☐		
Domiciliary Services in an IOP or PHP setting (program must be approved by UHC)	☐	☐		
Chronically Mentally Ill Services (CMI)/Severely Mentally Ill Services (SMI)	☐	☐		
Respite Care Services	☐	☐		
Emergency Room Services (assessment only)	☐	☐		
Twenty-three (23) Hour Crisis Observation	☐	☐		
Mobile Crisis Stabilization (State assigned county)	☐	☐		
MHSA Outpatient Clinics in a hospital	☐	☐		
Medication Assisted Treatment (MAT) – available in requested levels of care (Must meet State TN program requirements) Type:	☐	☐		
Sober Living Halfway House	☐	☐		
Group Home	☐	☐		
Therapeutic Foster Care	☐	☐		
Community-based Acute Treatment for Children and Adolescents (CBAT)	☐	☐		
Intensive Community-based Acute Treatment for Children and Adolescents (ICBAT)	☐	☐		
ASAM Residential Services *3.1 – Clinically Managed Low Intensity Res. – Medicaid only*	☐	☐		
Community-based Acute Treatment for Children and Adolescents (CBAT)	☐	☐		

Agency Clinician Specialty Attestation

We require additional training, experience and/or outside agency approval for the following populations, professionals and specialties. Please review the Specialty Requirements on the following pages. If you are not requesting a specialty designation, please check the "No Specialties" box at the bottom of the list to indicate you have read this form and acknowledge that you have not requested these specialties.

Physician Specialties

- ☐ Child/Adolescent (please specify all ages that you treat):
  - ☐ Infant Mental Health *(0-3 years)*
  - ☐ Preschool *(0-5 years)*
  - ☐ Children *(6-12 years)*
  - ☐ Adolescents *(13-18 years)*
- ☐ Geriatrics
- ☐ Buprenorphine – Medication Assisted Treatment (MAT) *(submit DEA registration with the DATA 2000 prescribing identification number)*
- ☐ Certified Group Psychotherapist (CGP) *(submit Certification from IBCGP)*
- ☐ Chemical Dependency / Substance Abuse / Substance Use Disorder (SUD)
- ☐ Child and Adolescent Strengths and Needs (CANS) 2.0 Assessor *(submit documentation of completion of training and certification as Assessor)*
- ☐ Child and Adolescent Strengths and Needs (CANS) 2.0 (Child Welfare) Assessor *(submit documentation of completion of training and certification as Assessor)*
- ☐ Cognitive Processing Therapy (CPT)
- ☐ Community Support Team (CST)
- ☐ Comprehensive Multi-Disciplinary Evaluation (CMDE)
- ☐ Coordinated Specialty Care (CSE)
- ☐ Developmental Relationship-Based Intervention (DRBI) *(submit copy of certification)*
- ☐ Early Intensive Developmental and Behavioral Intervention (EIDBI)
- ☐ Medicaid Office-Based Opioid Treatment Program (OBOT)
- ☐ Neuropsychological Testing
- ☐ Office-Based Addictions Treatment (OBAT)
- ☐ Prolonged Exposure (PE)
- ☐ Substance Abuse Expert *(submit Nuclear Regulatory Commission qualification training certificate)*
- ☐ Transcranial Magnetic Stimulation (TMS)
- ☐ Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) *(submit copy of TF-CBT certification)*
- ☐ Trauma Informed Care (TIC) *(submit documentation of completion of TIC training)*
- ☐ Triple P (Positive Parenting Program) *(submit copy of certification in Triple P – Standards Level 4)*
- ☐ Trust-Based Relational Intervention (TBRI) *(submit documentation of completion of TBRI training)*

Non-Physician Specialties

- ☐ Child/Adolescent (please specify all ages that you treat) – *Psychologist only*:
  - ☐ Infant Mental Health *(0-3 years)*
  - ☐ Preschool *(0-5 years)*
  - ☐ Children *(6-12 years)*
  - ☐ Adolescents *(13-18 years)*
- ☐ Assertive Community Treatment (ACT) *(requires Cover Sheet and Score Sheet from SAMHSA ACT Evidence-Based Practice Toolkit)*
- ☐ Certified Group Psychotherapist (CGP) *(submit Certification from IBCGP)*
- ☐ Chemical Dependency / Substance Abuse / Substance Use Disorder (SUD)
- ☐ Child and Adolescent Strengths and Needs (CANS) 2.0 Assessor *(submit documentation of completion of training and certification as Assessor)*
- ☐ Child and Adolescent Strengths and Needs (CANS) 2.0 (Child Welfare) Assessor *(submit documentation of completion of training and certification as Assessor)*
- ☐ Cognitive Processing Therapy (CPT)
- ☐ Community Support Team (CST)
- ☐ Comprehensive Multi-Disciplinary Evaluation (CMDE)
- ☐ Coordinated Specialty Care (CSC)
- ☐ Critical Incident Stress Debriefing *(requires CISD certificate)*
- ☐ Developmental Relationship-Based Intervention (DRBI) *(submit copy of certification)*
- ☐ Early Intensive Developmental and Behavioral Intervention (EIDBI)
- ☐ Functional Family Therapy (FFT)
- ☐ Functional Family Therapy – Child Welfare (FFT-CW)
- ☐ Homebuilders® - Homebuilders Family Preservation Program
- ☐ Multi-Systemic Therapy (MST)
- ☐ Neuropsychological Testing – *Psychologists only*
- ☐ Nurses and Physician Assistants – Buprenorphine – Medication Assisted Treatment (MAT) *(submit certification email from DEA)*
- ☐ Nurses – Prescriptive Privileges *(requires ANCC certificate, Prescriptive Authority, DEA certificate and/or State Controlled Substance certificate, based on state requirements)*
- ☐ Office-Based Addictions Treatment (OBAT)
- ☐ Peer Bridger/Support Services *(requires state peer certification or evidence of current training completion)*
- ☐ Prolonged Exposure (PE)

NON-PHYSICIAN SPECIALTIES (CONT.)
☐ Substance Abuse Expert *(submit Nuclear Regulatory Commission qualification training certificate)*
☐ Substance Abuse Professional *(submit Department of Transportation certificate)*
☐ Transcranial Magnetic Stimulation (TMS)
☐ Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) *(submit copy of TF-CBT certification)*
☐ Trauma Informed Care (TIC) *(submit documentation of completion of TIC training)*
☐ Triple P (Positive Parenting Program) *(submit copy of certification in Triple P – Standards Level 4)*
☐ Trust-Based Relational Intervention (TBRI) *(submit documentation of completion of TBRI training)*
☐ Veterans Administration Mental Health Disability Examination *– Psychologist only*

As an Authorized Agency Representative, I have reviewed the Specialty Requirements criteria that a Clinician must meet to be considered a specialist in the following treatment areas. After reviewing the criteria, I hereby attest that by placing a check next to a specialty or specialties, our Agency includes at least one clinician who meets UHCCP requirements for that treatment area. Any specialties indicated will be included in online directory information for member referral purposes.

For those specialties that require specific documentation, I further attest that such documentation is retained by the Agency and is available to UHCCP upon request.

I understand that UHCCP may require documentation to verify that a clinician or clinicians within this Facility/Agency meet(s) the criteria outlined under Specialty Requirements pertaining to the specialty or specialties I have designated above. The Facility/Agency will cooperate with an UHCCP documentation audit, if requested, to verify that a clinician or clinicians meet(s) the required criteria.

I hereby attest that all of the information above is true and accurate to the best of my knowledge. I understand that any information provided pursuant to this attestation that is subsequently found to be untrue and/or incorrect could result in termination from the UHCCP network.

By checking the box below, I am indicating that no clinicians in this Facility/Agency meet the above criteria.

☐ **No Specialties**

Please note that standard credentialing criteria must be met before specialty designation can be considered. An authorized representative must sign this form whether any specialty designations are being requested or not. Failure to sign this form may cause a delay in the processing of the Facility/Agency credentialing file.

Printed Name of Authorized Facility/Agency Representative

Signature of Authorized Facility/Agency Representative
(Signature stamps not accepted)

Date

PHYSICIAN SPECIALTY REQUIREMENTS
Important note: Signature on the previous Specialty Attestation page is required for all applicants.
CHILD/ADOLESCENT • Completion of an ACGME approved Child and Adolescent Fellowship ***OR*** recognized certification in Adolescent Psychiatry (specialty includes infants, preschool, children and adolescents)
GERIATRICS: • Completion of an ACGME approved Geriatric Fellowship ***OR*** recognized certification in Geriatric Psychiatry
BUPRENORPHINE – MEDICATION ASSISTED TREATMENT (MAT) • DEA registration certificate with the DATA 2000 prescribing identification number
CERTIFIED GROUP PSYCHOTHERAPIST • Must have Board Certification from the International Board for Certification of Group Psychotherapists (IBCGP)
CHEMICAL DEPENDENCY / SUBSTANCE ABUSE / SUBSTANCE USE DISORDER (SUD) • Completion of an ACGME board certification in addiction psychiatry ***OR*** certification in addiction medicine ***OR*** certified by the American Society of Addiction Medicine (ASAM)/renamed American Board of Addiction Medicine
CHILD and ADOLESCENT NEEDS AND STRENGTHS (CANS) 2.0 ASSESSOR • Must have completed training on CANS and be certified as an Assessor
CHILD and ADOLESCENT NEEDS AND STRENGTHS (CANS) 2.0 (CHILD WELFARE) ASSESSOR • Must have completed training on CANS and be certified as an Assessor
COGNITIVE PROCESSING THERAPY (CPT) • Licensed mental health provider must complete training in CPT by approved trainer • Must complete 2 cases to acceptable fidelity to the model under consultation with an expert consultant
COMMUNITY SUPPORT TREATMENT (CST) • Must meet state requirements
COMPREHENSIVE MULTI-DISCIPLINARY EVALUATION (CMDE) • Must meet Department of Human Services (DHS) Early Intensive Developmental and Behavioral Intervention (EIDBI) requirements
COORDINATED SPECIALTY CARE (CSC) • Must meet state requirements
DEVELOPMENTAL RELATIONSHIP-BASED INTERVENTION (DRBI) • Requires certification in DRBI
EARLY INTENSIVE DEVELOPMENTAL AND BEHAVIORAL INTERVENTION (EIDBI) • Must meet Department of Human Services (DHS) Early Intensive Developmental and Behavioral Intervention (EIDBI) requirements
MEDICAID OFFICE-BASED OPIOID TREATMENTPROGRAM (OBOT) • State certificate, if applicable in your state
MEDICARE OPIOID TREATMENT PROGRAM • Requires certification from the Substance Abuse and Mental Health Administration (SAMHSA) and DEA
NEUROPSYCHOLOGICAL TESTING • Recognized certification in Neurology through the American Board of Psychiatry and Neurology **OR** • Accreditation in Behavioral Neurology and Neuropsychiatry through the American Neuropsychiatric Association **AND all of the following criteria:** • State medical licensure specifically allows for provision of neuropsychological testing service • Evidence of professional training and expertise in the specific tests and/or assessment measures for which authorization is requested • Physician and supervised psychometrician adhere to the prevailing national professional and ethical standards regarding test administration, scoring, and interpretation
OFFICE-BASED ADDITIONS TREATMENT (OBAT) • Provider must have hired a Navigator to assist with OBAT services
PROLONGED EXPOSURE (PE) • Licensed mental health provider must complete training in PE by approved trainer • Must complete 2 cases to acceptable fidelity to the model under consultation with an expert consultant
SUBSTANCE ABUSE EXPERT (SAE) – Nuclear Regulatory Commission (NRC) • Certificate of NRC SAE qualification training (agencies providing such certification include, but are not limited to, ASAP, Inc., Program Services, and SAPAA)
TRANSCRANIAL MAGNETIC STIMULATION (TMS) • Completion of all training related to use of FDA-cleared device(s) to be used in accordance with FDA-labeled indication

TRAUMA-FOCUSED COGNITIVE BEHAVIORAL THERAPY (TF-CBT) • Must have obtain a certification from the Trauma-Focused Cognitive Behavioral Therapy National Therapist Certification Program
TRAUMA INFORMED CARE (TIC) • Must have completed training in Trauma Informed Care
TRIPLE P (Positive Parenting Program) • Must have an accreditation certification in Triple P – Standards Level 4, issued by Triple P America
TRUST-BASED RELATIONAL INTERVENTION (TBRI) • Must have completed training in Trust-Based Relational Intervention

PSYCHOLOGISTS, NURSES & MASTER'S LEVEL CLINICIANS SPECIALTY REQUIREMENTS
CHILD/ADOLESCENT – Psychologists Only • Completion of an APA approved or other accepted training/certification program in Clinical Child Psychology (this specialty includes Infants, Preschool, Children and Adolescents)
CERTIFIED GROUP PSYCHOTHERAPIST • Must have Board Certification from the International Board for Certification of Group Psychotherapists (IBCGP)
CHEMICAL DEPENDENCY / SUBSTANCE ABUSE / SUBSTANCE USE DISORDER (SUD) • Completion of an APA or other accepted training in Addictionology **OR** • Certification in Addiction Counseling **AND one (1) or more of the following:** • Ten (10) hours of CEU in Substance Abuse in the last twenty-four (24) month period • Evidence of at least twenty-five percent (25%) of practice experience in substance abuse
CHILD and ADOLESCENT NEEDS AND STRENGTHS (CANS) 2.0 ASSESSOR • Must have completed training on CANS and be certified as an Assessor
CHILD and ADOLESCENT NEEDS AND STRENGTHS (CANS) 2.0 (CHILD WELFARE) ASSESSOR • Must have completed training on CANS and be certified as an Assessor
COGNITIVE PROCESSING THERAPY (CPT) • Licensed mental health provider must complete training in CPT by approved trainer • Must complete 2 cases to acceptable fidelity to the model under consultation with an expert consultant
COMMUNITY SUPPORT TEAM TREATMENT (CST) • Must meet state requirements
COMPREHENSIVE MULTI-DISCIPLINARY EVALUATION (CMDE) • Must meet Department of Human Services (DHS) Early Intensive Developmental and Behavioral Intervention (EIDBI) requirements
COORDINATED SPECIALTY CARE (CSC) • Must meet state requirements
CRITICAL INCIDENT STRESS DEBRIEFING • Certificate of CISD training from American Red Cross or Mitchell model • Documentation of training and CEU units in the provision of CISD services
EARLY INTERVENTION PROVIDER (Virginia Medicaid Only) • Must be certified by the Department of Behavioral Health and Developmental Services (DBHDS) to provide Early Intervention services in accordance with 12 VAC 30-50-131 • Providers of Early Intervention Care Management/Service Coordination must be certified through DBHDS as a Service Coordinator
NEUROPSYCHOLOGICAL TESTING – Psychologists Only • Member of the American Board of Clinical Neuropsychology OR the American Board of Professional Neuropsychology **OR** • Completion of courses in Neuropsychology, including: Neuroanatomy, Neuropsychological Testing, Neuropathology, or Neuropharmacology • Completion of an internship, fellowship, or practicum in Neuropsychological Assessment at an accredited institution **AND** • Two (2) years of supervised professional experience in Neuropsychological Assessment
NURSES & PHYSICIAN ASSISTANTS - BUPRENORPHINE – MEDICATION ASSISTED TREATMENT: • Certification from DEA

NURSES REQUESTING PRESCRIPTIVE AUTHORITY MUST:

- Possess a currently valid license as a Registered Nurse in the state(s) in which you practice
- Be authorized for prescriptive authority in the state in which you practice
- Meet state specific mandates for the state in which you practice regarding DEA license and physician supervision
- Attest that you meet your state's collaborative or supervisory agreement requirements
- Specifically request prescriptive privileges on the attestation (page 10)

OFFICE-BASED ADDITIONS TREATMENT (OBAT)

- Provider must have hired a Navigator to assist with OBAT services

PROLONGED EXPOSURE (PE)

- Licensed mental health provider must complete training in PE by approved trainer
- Must complete 2 cases to acceptable fidelity to the model under consultation with an expert consultant

SUBSTANCE ABUSE EXPERT (SAE) – Nuclear Regulatory Commission (NRC)

To qualify as an SAE for the NRC, you must possess one of the following credentials:

- Licensed or certified social worker
- Licensed or certified psychologist
- Licensed or certified employee assistance professional
- Certified alcohol and drug abuse counselor – The NRC recognizes alcohol and drug abuse certification by the National Association of Alcoholism and Drug Abuse Counselors Certification Commission (NAADAC) or by the International Certification Reciprocity Consortium/Alcohol and Other Drug Abuse (ICRC/AODA)

AND

- Certificate of NRC SAE qualification training (agencies providing such certification include, but are not limited to, ASAP, Inc., Program Services, and SAPAA)

SUBSTANCE ABUSE PROFESSIONAL (SAP)

- Certificate of training in federal Department of Transportation SAP functions and regulatory requirements (agencies providing such certification include, but are not limited to, Blair and Burke, EAPA and NMDAC)

TRANSCRANIAL MAGNETIC STIMULATION (TMS)

- Completion of all training related to use of FDA-cleared device(s) to be used in accordance with FDA-labeled indication
- Must be within the scope of state license

TRAUMA-FOCUSED COGNITIVE BEHAVIORAL THERAPY (TF-CBT)

- Must have obtain a certification from the Trauma-Focused Cognitive Behavioral Therapy National Therapist Certification Program

TRAUMA INFORMED CARE (TIC)

- Must have completed training in Trauma Informed Care

TRIPLE P (Positive Parenting Program)

- Must have an accreditation certification in Triple P – Standards Level 4, issued by Triple P America

TRUST-BASED RELATIONAL INTERVENTION (TBRI)

- Must have completed training in Trust-Based Relational Intervention

VETERANS ADMINISTRATION MENTAL HEALTH DISABILITY EXAMINATION – Psychologist Only

- Graduate of an American Psychological Association accredited university (qualification counts even if accreditation occurred after date of graduation)
- Wheelchair accessible office
- PC user (Macintosh/Mac computers do not interface with the testing software used in the Disability Examination)
- Agree to participate in initial and annual training programs as required by LHI
- Agree to offer appointments within 10 to 14 days of the request for services
- Agree that beneficiary will not wait longer than 20 minutes in the office before being tested

PEER BRIDGER / SUPPORT SPECIALIST

PEER BRIDGER/SUPPORT SPECIALISTS MUST:

- In states that offer a certification program, possess a currently valid Peer Support Certification
- In states that do not offer a certification program, have completed peer support training through an approved program and passed an exam. Training must have been completed through one of the following approved programs:
  - Appalachian Consulting
  - Depression and Bipolar Support Alliance
  - Georgia State Model
  - Mental Health Association of Southeastern Pennsylvania
  - NAZCARE
  - Recovery Innovations
  - Transformation Center
  - Mountain States
  - Other (Any other training program on Peer Support Services must be submitted for review and approval by UnitedHealthcare prior to credentialing or contracting)

AGENCY
ASSERTIVE COMMUNITY TREATMENT (ACT): • Must submit Cover Sheet and Score Sheet from Substance Abuse and Mental Health Services Administration (SAMHSA) Assertive Community Treatment (ACT) Evidence-Based Practice Toolkit
CHEMICAL DEPENDENCY / SUBSTANCE ABUSE / SUBSTANCE USE DISORDER (SUD) • Agency is licensed by the state to provide outpatient treatment for chemical dependency/substance abuse/substance use disorder
BUPRENORPHINE – MEDICATION ASSISTED TREATMENT (MAT) • Entity level certification from Substance Abuse and Mental Health Services Administration (SAMHSA)
FUNCTIONAL FAMILY THERAPY (FFT) • Must be certified by Institute for FFT, Inc.
FUNCTIONAL FAMILY THERAPY – CHILD WELFARE (FFT-CW) • Must have certification of FFT license with FFT-CW specialty issued by Institute for FFT, Inc.
HOMEBUILDERS® – HOMEBUILDERS FAMILY PRESERVATION PROGRAM • Must be certified by the Institute for Family Development (IFD)
MULTI-SYSTEMIC THERAPY (MST) • Must have current license, issued by MST Services, to provide multi-systemic therapy

UHCCP INTERNAL USE ONLY

Facility: _____ TIN: _____ Facets # (if applicable) _____

CONTRACTING REP / ASSOCIATE

Name: _____ Date Received: _____ Date Reviewed: _____

Networks (check all that apply): ☐ Commercial ☐ Medicare ☐ Medicaid Other: _____

# of Covered Lives: _____ Current Network (# of PAR facilities offering same level(s) of care: _____

Network Needs (based on access standards): _____

If network need is determined, Network Manager verified levels of care with facility (**including UHCCP Level of Care Guidelines**).

Date: _____

Confirmed facility has reviewed Provider Manual, claims and clinical guidelines ☐ Yes ☐ No

PROVIDER SERVICES GOVERNANCE COMMITTEE OUTCOME

Reviewed by Provider Services Governance Committee: Date: _____

☐ **APPROVED (Rationale):** _____

☐ **DENIED (Rationale):** _____

Clinical Operation Representative Signature / Title: _____ Date: _____

Network Manager Signature: _____ Date: _____

Outcome Communicated to Facility by Network Manager (if approved, TN educated facility on next steps in process): Date:

CREDENTIALING CHECKLIST
(Only if approved)

Sent to Facility Credentialing Team:

Date: Application set via: ☐ SalesForce ☐ Email

CMS Disclosure Form Attached (required for all State Medicaid providers) ☐ Yes ☐ No/Not Applicable

Site audit request form completed (if applicable): ☐ Yes ☐ No/Not Applicable

Exception Form needed: ☐ Yes ☐ No/Not Applicable

If "Yes", reason for exception: _____

Additional comments: