Board certified behavior analyst/agency network participation form

Please read carefully:

- In order to be considered for network participation, you must fully complete all responses. Incomplete forms will delay the response regarding consideration.

Provider information

☐ Individual board certified behavior analyst (BCBA) provider in private practice

☐ Agency provider (indicate total staff numbers within the agency):

Licensed behavioral clinicians: ☐ MD ☐ PhD ☐ MSW ☐ RN

BCBA:	Licensed by state? ☐ Yes ☐ No
Paraprofessionals/tutors:	Licensed by state? ☐ Yes ☐ No
RBT/nationally certified? ☐ Yes ☐ No	Certified by state? ☐ Yes ☐ No
Provider name:	Name practice (DBA):

Practice address:

City:	State:	ZIP:

Please indicate if treatment is provided at your private residence. ☐ Yes ☐ No

Phone number:	Fax number:

Email:

Correspondence address: (credentialing/recredentialing: (P.O. Box address is not acceptable)

City:	State:	ZIP:

Contact name (if other than yourself):

Phone number:	Fax number:

Email:

Remittance address:

City:	State:	ZIP:

Agency service area (Counties):	
How long has your agency been established? Years:	How long providing ABA/IBT svcs?
Does your agency utilize televideo technology for supervision or other activities? If yes, please explain:	
List the types of intensive behavior approaches your agency utilizes:	
List all languages (including sign language) in which you are able to conduct treatment:	

Optional – Clinician's own ethnicity (data utilized to meet member referral requests):

☐ African American	☐ Alaska Native	☐ Native American Indian	☐ Asian
☐ Caucasian	☐ Hispanic	☐ Native Hawaiian or Pacific Islander	
☐ Other:			

Provider identification information:
(If agency provider, please complete information for one BCBA on staff)

Tax ID number: (TIN)**	
ABA/IBT national accreditation number and expiration date:	Date:
Behavior analyst board certification number(s) and expiration date:	Date:
National Provider Identifier (NPI) number: NU:	MN:
Social Security number:	
CAQH number:	Date of birth:
Name of liability insurance carrier:	
Policy number:	
Liability insurance coverage amounts per occurrence/aggregate:	
Liability insurance effective date:	Term date:

**If you have more than 1 TIN/group affiliation, please list additional affiliations	
Name of group/practice:	TIN:
Name of group/practice:	TIN:
Name of group/practice:	TIN:
Name of group/practice:	TIN:
Name of group/practice:	TIN:

ABA specialty requirements

Individual BCBA:

- Board Certified Behavior Analyst (BCBA) with active certification from the national Behavior Analyst Certification Board, and
- State licensure in those states that license behavior analysts
- State certification in those states that certify behavior analysts
- Compliance with all state/autism mandate requirements as applicable to behavior analysts
- A minimum of 6 months of supervised experience or training in the treatment of applied behavior analysis/intensive behavior therapies
- Minimum professional liability coverage of $1 million per occurrence/$1 million aggregate

Agency provider:

- BCBAs must meet standards above and hold supervisory certification from the national Behavior Analyst Certification Board if in supervisory role
- Licensed clinicians must have appropriate state licensure and 6 months of supervised experience or training in the treatment of applied behavior analysis/intensive behavior therapies
- Compliance with all state/autism mandate requirements as applicable to behavior analysts /ABA practices
- BCaBAs must have active certification from the national Behavior Analyst Certification Board, and appropriate state licensure in those states that license assistant behavior analysts
- Paraprofessionals must have RBT certification from the national Behavior Analyst Certification Board, or alternative national board certification, and receive appropriate training and supervision by BCBAs or licensed clinician
- BCBA or licensed clinician on staff providing program oversight

ABA specialty requirements (cont.)

- BCBA or licensed clinician performs skills assessments and provides direct supervision of paraprofessionals in joint sessions with client and family
- $1 million/occurrence and $3 million/aggregate of professional liability and $1m/$1m of general liability if services are provided in a clinic setting
- $1million/occurrence and $3million/aggregate of professional liability and $1m/$1m of supplemental insurance if the agency provides ambulatory services only (in the patient's home).

ABA specialty attestation requirements:

I have reviewed the UnitedHealthcare Community Plan (UHCCP) ABA specialty requirements that I must meet to be credentialed and contracted as a BCBA and/or ABA agency care provider. After reviewing the requirements, I hereby attest that by placing a check next to this specialty, I meet UHCCP requirements for this treatment area.

☐ Solo BCBA with required experience in applied behavior analysis/intensive behavior therapies
☐ Agency provider with required experience in applied behavior analysis/intensive behavior therapies

Areas of clinical expertise:

Please indicate populations served and in which you have applied behavior analysis/intensive behavior therapy training and experience for the treatment of autism spectrum disorder and the type of program(s) for which you provide services.

Applied behavior analysis/Intensive behavior therapies for autism spectrum disorder (populations served)	
☐ Preschool (0–5 years)	☐ Adolescents (13–18 years)
☐ Children (6–12 years)	☐ Adults (18–21 years)
Clinic-based programs	
☐ Full-day; 5 days a week 6 hours a day	☐ Intensive outpatient, 3 days a week, 3 hours a day
☐ Half-day; 5 days a week, 3 hours a day	☐ Other (please specify):
Non-clinic-based programs	
☐ Home-based (10–40 hours a week)	☐ Other (please specify) :
☐ Community-based (3–6 hours a week)	

Contracted UHCCP providers have the following rights to:

- Review information submitted to support their (re)credentialing application
- Correct erroneous information obtained by UHCCP to evaluate their (re)credentialing application (not including references, recommendations and other peer-review protected information)
- Submit any corrections, in writing, within 10 days
- Obtain information regarding the status of their application

I understand that UHCCP will require documentation to verify that I meet the criteria outlined under Specialty Requirements pertaining to the specialty designated above. I will cooperate with a UHCCP documentation audit, if requested, to verify that I meet 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 network provider request form and specialty attestation that is subsequently found to be untrue and/or incorrect could result in my termination from the UHCCP network.

Please note that standard credentialing criteria must be met before specialty designation can be considered. All care providers must sign this form. Failure to sign this form may cause a delay in the processing of your initial credentialing file.

Printed name of applicant /agency signatory designee:	Date:
Signature of applicant /agency signatory designee:	Date:

(Signature stamps are not accepted)

United Healthcare Community Plan