Join our network request - board certified behavior analyst/agency

UnitedHealthcare Community Plan of Washington

Please read carefully:

- In order to be considered for network participation, you must fully complete this form. Incomplete forms will delay the response.
- If accepted to formally apply to join the network, UnitedHealthcare Community Plan will provide you with access to the standard credentialing application for the state of Washington

Email completed application to: WAABACaid@uhc.com

Provider information:

☐ Individual Board-Certified Behavior Analysts (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? _____ Supervisory designation by BCBA? _____

Board-Certified Assistant Behavior Analysts (BCaBA) _____ Licensed by state? _____

Paraprofessionals/tutors _____ Registered Behavior Technicians®/nationally certified? _____

Provider name: _____

Name of practice (dba): _____

Practice address: _____

City _____ State _____

ZIP _____

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

Phone: _____ Fax: _____

Email: _____

Correspondence address: _____

(Credentialing/recredentialing) (P.O. Box address is not acceptable)

City _____ State _____

ZIP _____

Contact name (if other than yourself): _____

Phone: _____ Fax: _____

Email: _____

Remittance address: _____

City _____ State _____

ZIP _____

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Provider information (cont.):

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? ☐ Yes ☐ No
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 _____

Behavior Analyst Board Certification number(s)and expiration date_____

Behavior Analysts license number(s) and expiration date(s) _____

Additional state certification type and number (if applicable) _____

National provider identifier (NPI) number _____

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 one TIN/group affiliation, please list additional affiliations

_____ _____

ABA specialty requirements:

Individual BCBA –

• BCBA with active certification from the national Behavior Analyst Certification Board (BACB) ***and***
• State licensure in those states that license behavior analysts

ABA specialty requirements (cont.):

- 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 BACB 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 BACB and appropriate state licensure in those states that license assistant behavior analysts
- Paraprofessionals must have RBT certification from the national BACB 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
- 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 $1 million/$1 million of general liability, if services are provided in a clinic setting
- $1 million/occurrence and $3 million/aggregate of professional liability and $1 million/$1 million of supplemental insurance, if the agency provides ambulatory services only (in the patient's home)

ABA Specialty Attestation Requirement:

I have reviewed the ABA Specialty Requirements above that I must meet to be credentialed and contracted as a Board-Certified Behavior Analyst and/or ABA Agency Provider. After reviewing the requirements, I hereby attest that by placing a check next to this specialty, I meet UnitedHealthcare Community Plan requirements for this treatment area.

☐ Solo BCBA with required experience in ABA/IBTs

☐ Agency Provider with required experience in ABA/IBTs

Areas of Clinical Expertise:

Please indicate populations served and in which you have ABA/IBT training and experience for the treatment of Autism Spectrum Disorder and the type of program(s) for which you provide services.

ABA/IBTs for Autism Spectrum Disorder (populations served)

☐ Preschool (0-5 years)

☐ Children (6-12 years)

☐ Adolescents (13-18 years)

☐ Adults (18-21 years)

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ABA Specialty Attestation Requirement (cont.):

Clinic-based programs

☐ Full-day; 5 days a week 6 hours a day ☐ Half-day; 5 days a week, 3 hours a day

☐ Intensive Outpatient, 3 days a week, 3 hours a day

☐ Other (please specify)_____

Non-clinic-based programs

☐ Home-based (10-40 hours a week) ☐ Community-based (3-6 hours a week)

☐ Other (please specify)_____

Contracted providers have the following rights:

- To review information submitted to support their (re)credentialing application
- To correct erroneous information obtained by UnitedHealthcare to evaluate their recredentialing application (not including references, recommendations and other peer-review protected information)
- To submit any corrections, in writing, within 10 days
- The right to obtain information regarding the status of their application

I understand that UnitedHealthcare 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 UnitedHealthcare 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 UnitedHealthcare Community Plan of Washington network.

Please note that standard credentialing criteria must be met before specialty designation can be considered. All 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: (Signature stamps are not accepted)

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