Placer County Systems of Care

County Use Only
LEIE:
Board Check:

□ Approved □ Denied
Date:
By:

Provider ID#: _____

MANAGED CARE INDIVIDUAL PROVIDER APPLICATION

Please complete all questions and submit all requested documentation.
Application cannot be processed if incomplete.

Profile:

Last Name:_____ First Name:_____ MI:_____

Gender: _____ Date of Birth (optional): _____ Ethnicity (optional): _____

Federal Tax ID#: _____ National Provider Identifier (NPI)#: _____

License Information:

Type:_____ State:_____ Number:_____ Expiration Date: _____

If you are a registered intern, who is your supervisor? _____

Note: The supervisor of an intern must be credentialed on the Placer County Provider Network. Placer County SOC should be notified of all locations/sites the intern works.

Mailing Address:

Street Address:_____Suite:_____

City:_____ State:_____Zip:_____County_____

Primary Office Address:

Street:_____Suite:_____

City:_____ County:_____ZIP:_____

Office Phone 1:_____ Office Phone 2: _____Fax:_____

E-mail Address:_____

Secondary Office Address: ☐ Not Applicable

Street:_____Suite:_____

City:_____ County:_____ZIP:_____

Office Phone 1:_____ Office Phone 2: _____Fax:_____

E-mail Address:_____

Billing Information: ☐ Billing address is the same as the Mailing Address above.

Street Address:_____Suite:_____

City:_____ State:_____Zip:_____County_____

Make Checks Payable to:_____

Practice Information:

Please complete the following practice information survey so that we might best match beneficiary needs with characteristics of your practice. Your Curriculum Vitae should reflect your training and expertise in the areas you select. (Is this a good place to request Special Training Certificates?)

Treatment Age Group Preferences:

I prefer and/or I am willing to provide services the following age groups. (check all that apply)

- ☐ Toddler (1-3)
- ☐ Young Child (4-6)
- ☐ Child (7-12)
- ☐ Teen (13-17)
- ☐ Young Adult (18-24)
- ☐ Adult
- ☐ Older Adult

Accommodation for Special Needs:

I am willing and able to accept clients who have: (check all that apply)

- ☐ Developmental Disability
- ☐ Hearing Impairment
- ☐ Speech Impairment

My office is: (check all that apply)

- ☐ Handicapped Accessible
- ☐ Near Public Transportation (1/2 mile)

Treatment Languages:

I speak the following language(s) fluently and can provide services in this/these language(s).

- ☐ English
- ☐ Spanish
- ☐ American Sign Language
- ☐ Russian
- ☐ Ukrainian
- ☐ Other(s): _____

Treatment Specialties:

Please check areas of specialty in which you have additional training (post-degree) or extensive experience. Checking the box means you have special expertise. If you do not check the box, it does not mean you will never be referred clients with these issues. (Check all that apply.)

- ☐ Brief Psychotherapy – Behavior Modification
- ☐ Brief Psychotherapy – Bereavement/Grief
- ☐ Brief Psychotherapy – Cognitive/Behavioral
- ☐ Brief Psychotherapy – EMDR
- ☐ Brief Psychotherapy – Family Therapy
- ☐ Brief Psychotherapy – Hearing Impaired
- ☐ Brief Psychotherapy – Hypnotherapy
- ☐ Brief Psychotherapy – Physical Disabilities
- ☐ Brief Psychotherapy – Play Therapy
- ☐ Brief Psychotherapy – Sexual Issues
- ☐ Brief Psychotherapy
- ☐ Chronic/severe mental illness
- ☐ Court Assessments
- ☐ CPS/Family Reunifications/Adoptions
- ☐ Dual Diagnosis/Co-occurring disorders
- ☐ Educational Testing
- ☐ Illness/Pain/Disabilities
- ☐ Medical Issues
- ☐ Medication Services (M.D. only)
- ☐ PCIT (Parent Child Interactive Therapy)
- ☐ Personality Disorders
- ☐ Chronic/severe mental illness

☐ Brief Psychotherapy – Solutions Focused

☐ Pet Assisted (Animal Assisted)

☐ Equestrian Therapy

☐ OTHER: _____

Culturally Specific Services:

I am able to provide culturally specific services, through my identity with this culture or because I have had extensive training to attain culturally competency/sensitivity in the following cultures. I am willing to take clients who request culturally specific services in this area (check all that apply).

☐ Ukrainian ☐ Asian Pacific ☐

☐ Mexican American ☐ Native American ☐ African American

☐ Gay/Lesbian/Transsexual/Bisexual ☐ Physically Disabled ☐ Developmentally Disabled

☐ Faith based – Christian ☐ Faith based – Jewish ☐ Faith based – Islamic

☐ New Age/ Spiritualism ☐ Faith based – Other: _____

☐ Other Cultural Specialty: *(Please specify)* _____

Professional References: *(List 3)*

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

Liability Insurance Information:

Carrier: _____ Policy #: _____ Expiration Date: _____

Coverage Limits: Per Incident (minimum 1 million): _____ Aggregate (minimum 3 million): _____

☐ Copy of proof of liability insurance is attached (required.)

Professional / Medical Education:

Medical / Professional School: _____ City: _____ State: _____

Degree Received: _____ Date Obtained: _____

Psychiatrist (M.D.) Supplemental Information:

UPIN#: _____ DEA#: _____

Board Certified: ☐Yes ☐No Board Name: _____ Date of Certification: _____

Board Eligible: ☐Yes ☐No Board Name: _____ Date of Certification: _____

Residency Institution Name: _____ Residency Institution City/State: _____

List Hospital/Clinic Affiliations with Name/Location: _____

ADDITIONAL COMMENTS: _____

ATTESTATION QUESTIONS

Please answer the following questions “yes” or “no””. If your answer to questions A through K is “yes” or if your answer to L is “no” please provide full details on separate sheet. If a question is not applicable, please mark answer(s) “No.”

A. Has your license to practice medicine in any jurisdiction, your Drug Enforcement Administration (DEA) registration or any applicable Narcotic registration in any jurisdiction ever been denied, limited, restricted, suspended, revoked, not renewed, or subject to probationary conditions, or an enforcement action, or have you voluntarily or involuntarily relinquished any such license or registration or voluntarily or involuntarily accepted any such actions or conditions, or have you been fined or received a letter of reprimand or is such action pending? Yes____ No____

B. Have you ever been charged, suspended, fined, disciplined, or otherwise sanctioned, subjected to probationary conditions, restricted or excluded, or have you voluntarily or involuntarily relinquished eligibility to provide services or accepted conditions on your eligibility to provide services, for reasons relating to possible incompetence or improper professional conduct, or breach of contract or program conditions, by Medicare, Medicaid, or any public program, or is any such action pending? Yes____No____

C. Have your clinical privileges, membership, contractual participation or employment by any medical organization (e.g. hospital medical staff, medical group, independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (Pro), private payer (including those that contract with public programs), medical society, professional association, medical school faculty position or other health delivery entity or system), ever been denied, suspended, restricted, reduced, subject to probationary conditions, revoked or not renewed for possible incompetence, improper professional conduct or breach of contract, or is any such action pending? Yes____ No____

D. Have you ever surrendered, allowed to expire, voluntarily or involuntarily withdrawn a request for membership or clinical privileges, terminated contractual participation or employment, or resigned from any medical organization (e.g., hospital medical staff, medical group, independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO), medical society, professional association, medical school faculty position or other health delivery entity or system) while under investigation for possible incompetence or improper professional conduct, or breach of contract, or in return for such an investigation not being conducted, or is any such action pending? Yes____No____

E. Have you ever surrendered, voluntarily withdrawn, or been requested or compelled to relinquish your status as a student in good standing in any internship, residency, fellowship, or other clinical education program? Yes____No____

F. Has your membership or fellowship in any local, county, state, regional, national, or international professional organization ever been revoked, denied, reduced, limited, subjected to probationary conditions, or not renewed, or is any such action pending? Yes____ No____

G. Have you been denied certification/re-certification by a specialty board, or has your eligibility, certification or re-certification status changed (other than changing from eligible to certified)? Yes____ No____

H. Have you ever been convicted of any crime (other than a minor traffic violation)? Yes____ No____

I. Do you presently use any drugs illegally? Yes____No____ If yes, please explain on a separate sheet of paper

J. Do you have a history of chemical dependency and/or substance abuse? Yes____No____ If yes, please explain on a separate sheet of paper.

K. Have any judgments/arbitrations been entered against you, or settlements been agreed to by you within the last seven (7) years, in professional liability cases, or are there any filed and served professional liability lawsuits/arbitrations against you pending? Yes___ Complete below. No____

Year of Suit: _____Total Amt. of Payments: _____Nature of Suit: _____

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L. Has your professional liability insurance ever been terminated, not renewed, restricted, or modified (e.g. reduced limits, restricted coverage, surcharged), or have you ever been denied professional liability insurance, or has any professional liability carrier provided you with written notice of any intent to deny, cancel, not renew, or limit your professional liability insurance or its coverage of any procedures? Yes____ No____

M. Are you able to perform all the services required by your agreement with, or the professional staff bylaws of, the Healthcare Organization to which you are applying, with or without reasonable accommodation, according to accepted standards of professional performance and without posing a direct threat to the safety of patients? Yes____ No____

I hereby affirm that the information submitted in this Section XVI, Attestation Questions, and any addenda thereto is true, correct, and complete to the best of my knowledge and belief and is furnished in good faith. I understand that material omissions or misrepresentations result in denial of my application or termination of my privileges, employment, or physician participation agreement.

I understand that, as a panel member of the Placer County Mental Health Managed Care Plan, I must comply with the responsibilities and procedures as outlined in the Placer County Systems of Care Network Providers Manual and understand I will be placed on inactive status if I do not comply. I agree to accept the rates as established by the Placer/Sierra Mental Health Plan.

Print Name Here: _____

Signature: _____ Date: _____

NETWORK PROVIDER RIGHTS

A provider has the right to review information obtained by Placer/Sierra Mental Health Plan for the purpose of evaluating that provider's credentialing or re-credentialing application. This includes non-privileged information obtained from any outside source (e.g. malpractice insurance carriers, state licensing boards), but does not extend to review of information, references or recommendations protected by law from disclosure. A provider may request to review such information at any time by sending a written request via letter or fax to the Credentialing Department The Credentialing Manager or Supervisor will notify the provider within 72 hours of the date and time when such information will be available for review at the Credentialing Department located at 11716 Enterprise Drive, Auburn, CA 95603.

NOTIFICATION OF DISCREPANCY

Providers will be notified when information obtained by sources varied from information provided on the provider's application. Examples of information include reports of a provider's malpractice claims history, actions taken against a provider's license/certificate, suspension or termination of hospital privileges or board certification. Providers will be notified of the discrepancy at the time of primary source verification. Sources will not be revealed if information obtained is not intended for verification of credentialing elements or is protected from disclosure by law.

If a provider believes that erroneous information has been supplied by primary sources, the provider may correct such information by submitting written notification to the Credentialing Department. Notification must occur within 48 hours of the notification to the provider of a discrepancy as provided in Section I or within 24 hours of provider's review of his/her credentials as provided in Section I.

Upon receipt of notification from the practitioner, Placer/Sierra Mental Health Plan will re-verify the primary source information in dispute. If the primary source information has changed, correction will be made immediately to the provider's credentials file. The provider will be notified in writing, via letter or fax, that the correction has been made to his/her credentials file. If upon re-review primary source information remains inconsistent with provider's notification, the Credentialing Department will notify the provider via letter or fax. The provider may then provide proof of correction from the primary source to the Credentialing Department via letter or fax within 10 working days. The Credentialing Department will re-verify the primary source information if such documentation is provided. All information gathered will be presented at the Credentials Committee meeting for final review.

APPENDIX VII — PLACER/SIERRA MHP MEDI-CAL ATTESTATION FORM

I HEREBY CERTIFY under penalty of perjury that I am the official responsible for the administration of Community Mental Health Services for the provider named below; that I have not violated any of the provisions of Section 1090 through 1098 of the Government Code; that the amount for which reimbursement is claimed herein is in accordance with Chapter 3, Part 2, Division 5 of the Welfare and Institutions Code; Title 42, Code of Federal Regulations (CFR) Part 438, Sections 438.604, 438.606 and 438.608; and that to the best of my knowledge and belief this claim is in all respects true, correct, and in accordance with law. I agree and shall certify under penalty of perjury that all claims for services provided to county mental health clients have been provided to the clients by the provider listed below. The services were, to the best of my knowledge, provided in accordance with the clients' written treatment plans. I also certify that all information submitted to the Department is accurate and complete. I understand that payment of these claims will be from Federal and/or State funds, and any falsification or concealment of a material fact may be prosecuted under Federal and/or State laws.

I agree to keep for a minimum period of seven years from the date of service (for minors seven years after reaching the age of 18) a printed representation of all records, which are necessary to disclose fully the extent of services furnished to the clients. I agree to furnish these records and any information regarding payments claimed for providing the services, on request, within the State of California, to the California Department of Health Services; the Medi-Cal Fraud Unit: California Department of Mental Health; California Department of Justice; Office of the State Controller; U.S. Department of Health and Human Services; Managed Risk Medical Insurance Board; Placer County Health Services Department; or their dully authorized representatives.

Amounts claimed herein for the Healthy Families program are only for children between the ages of one (1) year old to their nineteenth (19th) birthday who were assessed or treated for a serious emotional disturbance (SED). I also agree that services are offered and provided without discrimination based on race, religion, color, national or ethnic origin, sex, age, or physical or mental disability.

I HEREBY CERTIFY under penalty of perjury to the following: An assessment of the beneficiaries was conducted in compliance with the requirements established in the Mental Health Plan (MHP) contract with the California Department of Mental Health (DMH). The beneficiaries were recorded in the State Medi-Cal Eligibility database as eligible to receive Medi-Cal services at the time the services were provided to them. The services included in the claim were actually provided to the beneficiaries. Medical necessity was established for the beneficiaries as defined under Title 9, California Code of Regulations, Division 1, Chapter 11, for the service or services provided, for the timeframe in which the services were provided.

A client plan was developed and maintained for each beneficiary that met all client plan requirements established in the MHP contract with DMH. For each beneficiary with day rehabilitation, day treatment intensive, or EPSDT supplemental specialty mental health services included in the claim, all requirements for MHP payment authorization in the MHP contract for day rehabilitation, day treatment intensive, and EPSDT supplemental specialty mental health services were met, and any reviews for such service or services

were conducted prior to the initial authorization and any re-authorization periods as established in the MHP contract with the DMH.

Signature: _____ **Date:** _____

Print Name Here: _____

Please attach the following documents:

☐ Copy of Professional License

☐ Copy of a Government issued Photo ID

☐ Copy of Liability Insurance Policy (Minimum coverage $1M per incident/ $3M aggregate)

☐ Federal Tax Form W-9

☐ California Form 591-Withholding Exemption Certificate

☐ Copy of NPI# received from the National Plan and Provider Enumeration System.

(Please see the page **How to Apply For Your NPI**)

How to Apply For Your NPI…

When applying, CMS urges you to include your legacy identifiers, not only for Medicare but for all payors. If reporting a Medicaid number, include the associated State name. This information is critical for payors in the development of crosswalks to aid in the transition to the NPI.

Health care providers can apply for NPIs in one of three ways:

- For the most efficient application processing and the fastest receipt of NPIs, use the web-based application process. Simply log onto the National Plan and Provider Enumeration System (NPPES) and apply online at www.npienumerator.com

- Health care providers can agree to have an Electronic File Interchange (EFI) organization (EFIO) submit application data on their behalf (i.e., through a bulk enumeration process) if an EFIO requests their permission to do so.

- Health care providers may obtain a copy of the paper NPI Application/Update Form (CMS-10114) and mail the completed, signed application to the NPI Enumerator located in Fargo, ND, whereby staff at the NPI Enumerator will enter the application data into NPPES. This form is available only upon request through the NPI Enumerator. Health care providers who wish to obtain a copy of this form must contact the NPI Enumerator at this number: 1-800-465-3203 or TTY 1-800-692-2326 or by mail at the following address: NPI Enumerator, P.O. Box 6059, Fargo, ND 58108-6059