Simply, the right choice.
COMMUNITY HEALTH PLAN

BEHAVIORAL HEALTH CENTER CREDENTIALING APPLICATION

SECTION I - PRACTICE INFORMATION

Name of Business: ____

Administrator: ____

Address:____
Street City

____
County State Zip Code

Office Telephone: ( )________________________ Fax#( )________________________

Office Manager's Name: ____

State License(s)#: ______________________ ______________________

Tax ID#: ______________________ (Attach a copy of W9 form)

Medicare Provider #:______________________Medicaid Provider #:______________________

National Provider ID#______________________

Office Hours:

HOURS	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
A.M.						
P.M.						

Are you accepting new patients? ❑ YES ❑ NO

Locations of all offices not listed above:

____
Street City County Zip Telephone

____
Street City County Zip Telephone

____
Street City County Zip Telephone

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Office Facility

1. How many parking spaces are available? How many spaces are set aside for handicapped usage?

2. Is there wheelchair/handicapped access to the building, including offices, treatment rooms, and restrooms?

3. Are exit signs visible?

4. Are fire extinguishers clearly visible and properly maintained?

5. Attach a copy of your evacuation plan.

Policy Statements

1. Please attach a copy of your organization's mission statement.

2. Explain the governance of your organization.

3. Please list the current program certifications:

4. What client education programs do you have?

5. Describe your client care model. Who determines which provider the client sees?

6. For which areas do you have a dedicated staff?

7. What types of clinical protocols do you have in place?

8. Are you willing to co-develop new pathways with partners such as Community Health Plan?

9. Are you willing to hold inservices with your staff on working with Community Health Plan?

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Scheduling

1. What is your office policy for scheduling routine appointments? Urgent or emergent requests? (How soon will clients be seen after contacting the office?)

2. What is the procedure for clients to access 24 hour call?

3. What is your policy and practice for handling requests for services that you do not have the capacity to accommodate?

Quality

1. Define your quality indicators.

2. What is your process for measuring outcomes?

3. Do you have the capacity to capture information on 100% of CHP members?

4. Please attach your current Quality Improvement Plan.

5. Do you have any TQM efforts in place? If so please explain and be specific.

6. What process do you follow when a problem or issue is discovered through your monitoring of indicators?

7. Do you have customer service representatives on staff? If so, briefly describe how they interact with your customers/clients.

8. What is your client satisfaction level? How is this measured? How frequently is it measured?

9. How do you measure the effectiveness of your client education programs? How frequently?

10. Can you provide monthly/quarterly utilization and quality reports to Community Health Plan? If so, please attach your most recent report giving all quality indicators.

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Medical Records

1. Describe your system of tracking and filing client records.

2. What protections/policies are in place to provide patient confidentiality and medical records secure?

Automation/computer Technology

1. Do you have the ability to submit electronic claims?

2. Describe your information systems.

Staffing

1. How many full time clinical staff do you have?

2. How many part time clinical staff do you have?

3. How many temporary clinical staff do you have?

4. What states are the staff licensed in?

5. (Please identify MD, DO, PhD, LCSW, LPC, etc…separately)

6. What is your staff turnover rate?

7. Do you measure employee satisfaction? If so, what is your current satisfaction rate?

8. What is your orientation/training plan or process for: Permanent staff? Part time staff?

9. How do you demonstrate successful completion of your orientation/training process?

10. How is your staff evaluated? How Frequently? By whom?

11. Do you consider an assessment by your clients in your employee's evaluation process? Assessment from peers?

12. Is any of your staff bilingual? If so, what languages?

13. Do you have staff that has skills to meet the needs of culturally diverse populations?

Credentialing

1. Describe your clinical staff credentialing process. Please attach an outline of this process.

2. How frequently are clinicians re-credentialed?

3. Do other employees go through a credentialing process? If so, please describe this process?

Professional Liability Coverage

1. Who is your Professional Liability Carrier?

2. How long have you had coverage through them?

3. What is the amount of your coverage?

4. Please list all practice cases and judgments in which the facility has been involved in the last 5 years. Indicate the amount of the settlements and the status of each case.

5. Have you ever lost your liability coverage? If so, please explain.

Attachments.

1. Evacuation Plan
2. Mission Statement
3. Quality Improvement Plan
4. Staff Credentialing Process
5. W9 Form
6. Accreditation Certificate
7. Medicare Certificate
8. State License
9. Professional Liability Insurance Certificate

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COMMUNITY HEALTH PLAN
STATEMENT OF APPLICATION
(Please read carefully before signing)

All information submitted by me on behalf of the organization noted below in this Application, and all documentation submitted by me in support of this Application, is true to the best of my knowledge and belief. I fully understand that any misleading statement or material omission in this Application may constitute cause for denial of eligibility.

By applying for membership in Community Health Plan, I hereby authorize Community Health Plan and its representatives to seek relevant information, whether written or oral, from health maintenance organizations, health plans (including employer-sponsored), institutions, state licensing and other regulatory boards, and professional organizations with which our organization has been associated, and with others, including past and present malpractice carriers (Health Care and Related Entities), who may have information bearing on the professional competence, character, and ethical qualifications. I hereby further consent to the inspection by Community Health Plan and its representatives of all documents that may be material to an evaluation of the organization's qualifications and competence as well as moral and ethical qualifications for eligibility. I hereby further authorize all Health Care and Related Entities to release to Community Health Plan and its authorized representatives any information, whether written or oral, with respect to the organization's, status with such Health Care and Related Entities pursuant to a written request from Community Health Plan, or its authorized representative, that such information be provided.

I hereby release from liability all representatives of Community Health Plan for their acts performed in good faith and without malice in connection with evaluating the Application.

I understand and agree that our organization, as an applicant for membership in Community Health Plan, have the burden of producing adequate information for proper evaluation of our professional competence, character, ethics, and other qualifications and for resolving any doubts about such qualifications. As such, I will before and after approval of this Application, notify Community Health Plan in writing of any changes, errors or omissions with respect to the information I have provided in this Application.

I authorize any State Licensing Board to release any and all information regarding the organization's licensure, past or present, proved or alleged violations, complaints, letters of concern issued, reprimands and any past or present disciplinary actions relating to the organization's license.

A photocopy of this Certification, Authorization and Release shall be as effective as the original when so presented.

Organization: ____

Name and Title:____
(Please print or type)

Signature:____ Date:____________________