Connecticut BHP
Supporting Health and Recovery

Dear Provider:

Thank you for your participation with the Medicaid Network and The CT Behavioral Health Partnership (CT BHP). An important aspect of the responsibilities of the CT BHP is the management of the provider file, and we want to ensure that we have the most accurate information. Please note that these forms are ***separate from and in addition to*** the DXC Technology enrollment application. Any change in contracting or credentialing information should be directed to DXC at (800) 842-8440 with any new or updated information.

Your completion of the forms accompanying this letter will allow CT BHP to:

- Track clinical services that you provide, allowing you to obtain authorizations for reimbursement.
- Update you on any and all policy changes, and new developments.
- Ensure that our clinical and customer service teams make appropriate referrals.
- Allow you to indicate how and when you would like to be contacted.

Please complete the attached Provider Data Verification Form, including signatures and return within 10 days of receipt. Be sure to copy and complete page (3) for **each** practice location. Completed forms can be faxed to (855) 750-9862 or mailed to:

**CT Behavioral Health Partnership**
**500 Enterprise Drive, Suite 4D**
**Rocky Hill, CT 06067**
**Attn: Provider Relations**

Sincerely,

Provider Relations Department
Connecticut Behavioral Health Partnership

# 1. PRACTITIONER INFORMATION

## A. PRIMARY DEMOGRAPHIC INFORMATION (* indicates required fields)

| | | | | |
|---|---|---|---|---|
| Last Name* | First Name* | | Middle Initial | ☐Male ☐Female |
| Mailing Address Line 1* | Mailing Address Line 2* | | | |
| City* | County* | State* | Zip* | Telephone*: (include area code) |
| Social Security Number * | Date of Birth * | Professional Designation or Title* | | Fax*: |
| Email Address* | | | | |
| Medicaid ID#* | NPI#* | | | |
| Tax Identification Number (TIN) * | | | | |

## B. GROUP INFORMATION

If you are part of more than (3) groups, please attach list of those Group Names and Numbers.

| | |
|---|---|
| **Are you part of a group?** | ☐ Yes ☐ No |
| If yes, Group Name(s) | Group Medicaid # |
| Group Name | Group Medicaid # |
| Group Name | Group Medicaid # |

# 2. REFERRAL INFORMATION

**A. LICENSED DISCIPLINE:** Indicate the discipline under which you are LICENSED and/or CERTIFIED at the highest level to practice independently.

☐ Psychiatrist -MD
☐ PHD, PSYD
☐ LCSW
☐ APRN
☐ LADC
☐ LPC
☐ LMFT
☐ Other (specify):_____

**Provider Signature: _____ Date: _____**

# 3. PRIMARY PRACTICE INFORMATION

## A. PRIMARY PRACTICE INFORMATION

*(If you have **more than one** practice location, please copy this page and complete for each location).*

| Practice Name | | | | |
|---|---|---|---|---|
| Practice Address Line 1 (street address required for referral purposes) | | Practice Address Line 2 | | |
| City | County | State | Zip | Appointment Telephone (incl. area code) |
| Office Manager (if applicable) | | Fax Number (include area code) | | |

**B. HOURS OF OPERATION** (actual practice hours each day at <u>this</u> location. (**e.g., 8:00am to 4:30pm)**

Include multiple practice hours **(e.g. 8:00 am to 12:00 pm. and 3 pm to 7 pm**):

| Monday | | Tuesday | | Wednesday | | Thursday | | Friday | | Saturday | | Sunday | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| From | To | From | To | From | To | From | To | From | To | From | To | From | To |
| | | | | | | | | | | | | | |
| From | To | From | To | From | To | From | To | From | To | From | To | From | To |
| | | | | | | | | | | | | | |

**Is this office handicapped accessible?** ☐ Yes ☐ No **Is this office accessible to public transportation?** ☐ Yes ☐ No

## 4. POPULATION TREATED

Identify the percentage of your practice dedicated to the following patient population categories (must total 100%):

| Population | % of Practice | GENDER | | | | Are You Currently Accepting New Patients? |
|---|---|---|---|---|---|---|
| | | M | F | Both | | |
| Child (0-5) (YC) | | | | | ⇒ | ☐ Yes ☐ No |
| Child (6-12) (CI) | | | | | ⇒ | ☐ Yes ☐ No |
| Adolescent (13–17) (AO) | | | | | ⇒ | ☐ Yes ☐ No |
| Adult (18-64) (AU) | | | | | ⇒ | ☐ Yes ☐ No |
| Geriatric (65+) (GT) | | | | | ⇒ | ☐ Yes ☐ No |

## 5. LANGUAGE

Identify any foreign language(s) or sign language that you use <u>fluently</u> in treating patients (Put an 'X' in no more than 5):

| | | | |
|---|---|---|---|
| ☐ American Sign Language (SG) | ☐ French (FR) | ☐ Italian (IT) | ☐ Russian (RU) |
| ☐ Arabic (AR) | ☐ German (GE) | ☐ Japanese (JA) | ☐ Spanish (SP) |
| ☐ Armenian (AN) | ☐ Greek (GR) | ☐ Korean (KO) | ☐ Swedish (SW) |
| ☐ Chinese (CH) | ☐ Hebrew (HE) | ☐ Norwegian (NW) | ☐ Tagalog/Filipino (PH) |
| ☐ Dutch (DU) | ☐ Hindi (HI) | ☐ Polish (PL) | ☐ Vietnamese (VI) |
| ☐ Farsi (FA) | ☐ Hungarian (HU) | ☐ Portuguese (PO) | ☐ Yiddish (YI) |
| | | ☐ Other (OT): _____ | |

**Provider Signature: _____ Date: _____**

**6. CLINICAL EXPERTISE (SPECIALTIES):** Please indicate **specialty areas** for which you have training and expertise at this location. These specialties will be used to assist *The CT Behavioral Health Partnership* in making clinically appropriate referrals. Please remember to put an 'X' in the applicable specialties when applying for the specialty networks.

| CLINICAL EXPERTISE | Please put an 'X' in applicable specialties. | THERAPEUTIC MODALITIES | Please put an 'X' in applicable specialties. |
|---|---|---|---|
| Addictions, Non-Chemical | | Critical Incident Stress Management | |
| Addictions, Chemical | | **Eye Movement Desensitization and Reprocessing (EMDR)** | |
| Anger Management/Impulse Disorders | | Neuropsychological Testing | |
| Applied Behavioral Analyst | | Play Therapy | |
| Attention Deficit Hyperactivity Disorder | | Psych Testing | |
| Autistic Disorder / Asperger Syndrome | | Psychopharmacology | |
| Chronic Pain | | | |
| Eating Disorders | | | |
| **Faith Based Counseling** | | | |
| **Forensics/Criminal Justice** | | | |
| Gangs/Cults | | | |
| Gay/Lesbian/Bisexual Issues | | | |
| Geropsychiatry/Alzheimers | | | |
| Head Trauma | | | |
| Hearing Impaired | | | |
| HIV / AIDS | | | |
| Mental Retardation / Developmental Disabilities | | | |
| Military Lifestyle Issues | | | |
| Panic/Phobias | | | |
| **Perinatal Mental Health** | | | |
| Physical Abuse Perpetrators | | | |
| Physical Abuse Victims | | | |
| Post-Traumatic Stress Disorder | | | |
| Reactive Attachment Disorder | | | |
| Schizophrenia | | | |
| **Transgender** | | | |
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**Provider Signature: _____ Date: _____**