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

- Ensure that our online Referral Connect application has the most up-to date information
- Allow our clinical and customer service teams make appropriate referrals.
- Help indicate how and when you prefer to be contacted.
- Track clinical services that you provide, allowing you to obtain authorizations for reimbursement.
- Update you on any and all policy changes, and new developments.

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.

Please complete the attached Provider Data Verification Form, including signatures and return within 10 days of receipt.

Completed forms can be emailed to CTBHP@beaconhealthoptions.com, or faxed to (855) 750-9862

Sincerely,

Provider Relations Department
Connecticut Behavioral Health Partnership

1. PRACTITIONER INFORMATION

a. Primary Demographic Information

Last Name	First Name	Middle Initial	☐Male ☐Female
Email Address			
Medicaid ID, NPI# or Tax Identification Number (TIN)			

b. Race/Ethnicity *Members seeking referrals will often request if they can obtain a listing of individual practitioners by race/ethnicity and/or gender. Voluntary Information: To meet the needs of Beacon Health Options clients and members, voluntary information is maintained about providers for referral and statistical purposes only. This information is released to members only upon specific request.*

☐African ☐American Indian or Alaskan Native ☐Arabic ☐Asian ☐Asian/Pacific American
☐Asian/Pacific Islander ☐Black (Not of Hispanic Origin) ☐Brazilian ☐Cambodian
☐Chinese ☐Christian ☐Cuban/Haitian ☐European ☐Haitian ☐Hindu ☐Hispanic Mexican
☐Hispanic or Latino ☐Hispanic/Latino 1 or More Races ☐Indian ☐Japanese ☐Jewish
☐Korean ☐Multi-Racial ☐Native American ☐Native Hawaiian ☐Pilipino ☐Romanian
☐Subcontinent Asian American ☐Unknown ☐Vietnamese ☐White (Not of Hispanic Origin)
☐Other ☐Prefer Not to Report

2. 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

3. REFERRAL INFORMATION

a. Hours of Operation

Please list actual practice hours each day at <u>this</u> location. I.e. **8:00am to 4:30pm.** If applicable, please include multiple practice hours **i.e. 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

b. 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

c. Language

Identify any foreign language(s) or sign language that you use fluently in treating patients Please list no more than five languages.

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

d. 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.

CLINICAL EXPERTISE			
Addictions, Non-Chemical		Physical Abuse Victims	
Addictions, Chemical		Post-Traumatic Stress Disorder	
Anger Management/Impulse Disorders		Reactive Attachment Disorder	
Applied Behavioral Analyst		Schizophrenia	
Attention Deficit Hyperactivity Disorder		Transgender	
Autistic Disorder / Asperger Syndrome		Head Trauma	
Chronic Pain		Hearing Impaired	
Eating Disorders		HIV / AIDS	
Faith Based Counseling		Mental Retardation / Developmental Disabilities	
Forensics/Criminal Justice		Military Lifestyle Issues	
Gangs/Cults		Panic/Phobias	
Gay/Lesbian/Bisexual Issues		Perinatal Mental Health	
Geropsychiatry/Alzheimer's		Physical Abuse Perpetrators	

THERAPEUTIC MODALITIES	
Critical Incident Stress Management	
Eye Movement Desensitization and Reprocessing (EMDR)	
Neuropsychological Testing	
Play Therapy	
Psych Testing	
Psychopharmacology	

By signing below, you certify that this above information is accurate and true:

Provider Signature: **Date:**