



Dear Provider:

Thank you for your participation with the HUSKY Health 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 Gainwell Technologies enrollment application. Any change in contracting or credentialing information should be directed to Gainwell 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](mailto: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	<input type="checkbox"/> Male <input type="checkbox"/> 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 this 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)					⇒	<input type="checkbox"/> Yes <input type="checkbox"/> No
Child (6-12) (CI)					⇒	<input type="checkbox"/> Yes <input type="checkbox"/> No
Adolescent (13-17) (AO)					⇒	<input type="checkbox"/> Yes <input type="checkbox"/> No
Adult (18-64) (AU)					⇒	<input type="checkbox"/> Yes <input type="checkbox"/> No
Geriatric (65+) (GT)					⇒	<input type="checkbox"/> Yes <input type="checkbox"/> 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.

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

**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:**