

M.H. Consultants, Inc.
Provider Network Membership Application

Please type or print clearly and complete entire application. Please include all attachments requested. Once completed, sign and return application to:

M.H. Consultants, Inc,
2500 York Rd., Suite 110
Jamison, PA 18929

Please attach the following to this application:

- Copies of all current valid state licenses. (If psychiatrist, must include DEA and CDS licenses)
- Copy of Professional Liability Insurance limits page. (Include CAT fund information if applicable)
- Current Professional Vita.
- Copies of All Certifications.
- Copy of Diploma. (When applicable, include foreign medical graduate certificate)

Applicant Information:

Name: _____ Degree: _____

Type of License: _____ (MD, Psychologist, LCSW, LPC, etc.)

S.S.N.: _____ Date of Birth: _____

Group/Professional Name: _____ T.I.N.: _____

Primary Office Address:

City: _____ State: _____ Zip: _____ County: _____

Office Phone: (_____) _____ Fax: (_____) _____

Other Phone: (_____) _____ Email: _____

Please Describe Office Setting:

Is Office Handicap Accessible: Y___ N___ Access to Public Transportation: Y___ N___

Does this location have?

Office Mgr/Admin: Y__ N__ Name: _____ Phone: _____

Billing Person: Y__ N__ Name: _____ Phone: _____

Medical Supervisor: Y__ N__ Name: _____ Phone: _____

Additional Office(s):

(2) Entity Name & TIN (If different from above): _____

Address: _____

City: _____ State: _____ Zip: _____ County: _____

Office Phone: (_____) _____ Fax: (_____) _____

Other Phone: (_____) _____ Email: _____

Please Describe Office Setting:

Does this location have?

Office Mgr/Admin: Y__ N__ Name: _____ Phone: _____

Billing Person: Y__ N__ Name: _____ Phone: _____

Medical Supervisor: Y__ N__ Name: _____ Phone: _____

Handicap Accessible: Y___ N___ Access to Public Transportation: Y___ N___

(3) Entity Name & TIN (If different from above): _____

Address: _____

M.H. Consultants, Inc.
Provider Network Membership Application

City: _____ State: _____ Zip: _____ County: _____
 Office Phone: (_____) _____ Fax: (_____) _____
 Other Phone: (_____) _____ Email: _____

Please Describe Office Setting:

Do You Have?

Office Mgr/Admin: Y__ N__ Name: _____ Phone: _____
 Billing Person: Y__ N__ Name: _____ Phone: _____
 Medical Supervisor: Y__ N__ Name: _____ Phone: _____
 Handicap Accessible: Y____ N____ Access to Public Transportation: Y____ N____
 After Hours / Emergency Coverage Arrangements (Include Names and Numbers):

Is Coverage Person(s) an MHC PPO Member? Y ____ N ____

If Additional Locations or Information, Please Attach a Separate Sheet

Billing Address (Check here if same as Primary Address Above ____):

City: _____ State: _____ Zip: _____

Your UCR (Retail Rates)

90801: _____	90806: _____	90862: _____
90809: _____	90847: _____	90853: _____
90808: _____	90805: _____	90807: _____
90808: _____	90804: _____	

Office Hours (Hours available for patient care)

	Primary Location	Other Location (2)	Other Location (3)	Other Locations
Monday				
Tuesday				
Wednesday				
Thursday				
Friday				
Saturday				
Sunday				

Other Pertinent Schedule Information: _____

Please briefly describe your theoretical orientation and the therapeutic techniques that you utilize:

Do you provide any other adjunctive services? (i.e.: biofeedback, hypnotherapy/hypnosis, Spiritual guidance, relaxation therapy) Y ____ N ____ If yes, please briefly describe:

Please list any languages (besides English) in which you are fluent:

M.H. Consultants, Inc.

Provider Network Membership Application

Clinical Services Provided

Please Check (✓) All Treatment Areas for which you provide treatment.

- Please Indicate:
 - C=Certification
 - S=Specialization

Treatment Areas

<p>ADJUSTMENT DISORDERS</p> <p><input type="checkbox"/> Loss/Grief</p> <p><input type="checkbox"/> Family Changes</p> <p><input type="checkbox"/> Legal Issues</p> <p><input type="checkbox"/> Medical/Chronic Illness Issues</p> <p><input type="checkbox"/> Geriatrics</p> <p><input type="checkbox"/> Other _____</p> <p>PERSONALITY DISORDERS</p> <p><input type="checkbox"/> Paranoid Personality Disorder</p> <p><input type="checkbox"/> Schizoid Personality Disorder</p> <p><input type="checkbox"/> Schizotypal Personality Disorder</p> <p><input type="checkbox"/> Antisocial Personality Disorder</p> <p><input type="checkbox"/> Borderline Personality Disorder</p> <p><input type="checkbox"/> Histrionic Personality Disorder</p> <p><input type="checkbox"/> Narcissistic Personality Disorder</p> <p><input type="checkbox"/> Avoidant Personality Disorder</p> <p><input type="checkbox"/> Dependent Personality Disorder</p> <p><input type="checkbox"/> Obsessive-Compulsive Personality Disorder</p> <p><input type="checkbox"/> Personality Disorder NOS</p> <p>ANXIETY DISORDERS</p> <p><input type="checkbox"/> Generalized Anxiety Disorder</p> <p><input type="checkbox"/> Panic Disorder</p> <p><input type="checkbox"/> Agoraphobia</p> <p><input type="checkbox"/> Specific phobia</p> <p><input type="checkbox"/> Social Phobia</p> <p><input type="checkbox"/> Obsessive-Compulsive Disorder</p> <p><input type="checkbox"/> Posttraumatic Stress Disorder</p> <p><input type="checkbox"/> Acute Stress Disorder</p> <p><input type="checkbox"/> Anxiety Disorder NOS</p> <p>ATTENTION-DEFICIT & DISRUPTIVE BEHAVIOR DISORDERS</p> <p><input type="checkbox"/> Attention-Deficit Hyperactivity Disorder</p> <p><input type="checkbox"/> Conduct Disorder</p> <p><input type="checkbox"/> Oppositional Defiant Disorder</p> <p><input type="checkbox"/> Disruptive Behavior Disorder NOS</p> <p>WORK ISSUES</p> <p><input type="checkbox"/> Career Counseling</p> <p><input type="checkbox"/> Employment Issues</p>	<p>ABUSE</p> <p><input type="checkbox"/> Sexual = <input type="checkbox"/> Victim <input type="checkbox"/> Perpetrator</p> <p><input type="checkbox"/> Physical = <input type="checkbox"/> Victim <input type="checkbox"/> Perpetrator</p> <p><input type="checkbox"/> Emotional= <input type="checkbox"/> Victim <input type="checkbox"/> Perpetrator</p> <p>COGNITIVE DISORDERS</p> <p><input type="checkbox"/> Delirium</p> <p><input type="checkbox"/> Dementia</p> <p><input type="checkbox"/> Amnesia</p> <p><input type="checkbox"/> Other: _____</p> <p>SUBSTANCE-RELATED DISORDERS</p> <p><input type="checkbox"/> Alcohol</p> <p><input type="checkbox"/> Drug</p> <p><input type="checkbox"/> Dual Diagnosis</p> <p><input type="checkbox"/> Tobacco Cessation</p> <p><input type="checkbox"/> Other: _____</p> <p>SLEEP DISORDERS</p> <p><input type="checkbox"/> Primary Hypersomnia</p> <p><input type="checkbox"/> Primary Insomnia</p> <p><input type="checkbox"/> Narcolepsy</p> <p><input type="checkbox"/> Breathing-Related Sleep Disorder</p> <p><input type="checkbox"/> Circadian Rhythm Sleep Disorder</p> <p><input type="checkbox"/> Dysomnia NOS</p> <p>DEVELOPMENTAL DISORDERS</p> <p><input type="checkbox"/> Autistic Disorder</p> <p><input type="checkbox"/> Rett's Disorder</p> <p><input type="checkbox"/> Childhood Disintegrative Disorder</p> <p><input type="checkbox"/> Asperger's Disorder</p> <p><input type="checkbox"/> Pervasive Developmental Disorder NOS</p> <p>IMPULSE-CONTROL DISORDERS</p> <p><input type="checkbox"/> Intermittent Explosive Disorder</p> <p><input type="checkbox"/> Kleptomania</p> <p><input type="checkbox"/> Pyromania</p> <p><input type="checkbox"/> Pathological Gambling</p> <p><input type="checkbox"/> Trichotillomania</p> <p><input type="checkbox"/> Impulse-Control Disorder NOS</p> <p>FACTITIOUS DISORDERS</p>	<p>SOMATOFORM DISORDERS</p> <p><input type="checkbox"/> Somatization Disorder</p> <p><input type="checkbox"/> Conversion Disorder</p> <p><input type="checkbox"/> Pain Disorder</p> <p><input type="checkbox"/> Hypochondriasis</p> <p><input type="checkbox"/> Body Dysmorphic Disorder</p> <p>PSYCHOTIC DISORDERS</p> <p><input type="checkbox"/> Schizophrenia</p> <p><input type="checkbox"/> Schizophreniform Disorder</p> <p><input type="checkbox"/> Schizoaffective Disorder</p> <p><input type="checkbox"/> Delusional Disorder</p> <p><input type="checkbox"/> Psychotic disorder NOS</p> <p>EATING DISORDERS</p> <p><input type="checkbox"/> Over eating</p> <p><input type="checkbox"/> Bulimia/Anorexia</p> <p>MOOD DISORDERS</p> <p><input type="checkbox"/> Bipolar Disorders</p> <p><input type="checkbox"/> Depressive Disorders</p> <p>DISSOCIATIVE DISORDERS</p> <p><input type="checkbox"/> Depersonalization disorder</p> <p><input type="checkbox"/> Dissociative Amnesia</p> <p><input type="checkbox"/> Dissociative Fugue</p> <p><input type="checkbox"/> Dissociative Identity Disorder</p> <p><input type="checkbox"/> Dissociative Disorder NOS</p> <p>LEARNING DISORDERS</p> <p><input type="checkbox"/> Reading Disorder</p> <p><input type="checkbox"/> Mathematics Disorder</p> <p><input type="checkbox"/> Disorder of Written Expression</p> <p><input type="checkbox"/> Learning Disorder NOS</p> <p>SEXUAL & GENDER IDENTITY DISORDERS</p> <p><input type="checkbox"/> Gender identity</p> <p><input type="checkbox"/> Dysfunction</p> <p><input type="checkbox"/> Other: _____</p> <p>OTHER ISSUES</p> <p><input type="checkbox"/> Marital</p> <p><input type="checkbox"/> Intimate Relationships (Paramour)</p> <p><input type="checkbox"/> Family</p> <p><input type="checkbox"/> Parenting</p>
--	---	--

M.H. Consultants, Inc. Provider Network Membership Application

(Clinical Services Provided-continued)

Are there any treatment areas that you have participated in 20 or more CEUs? Y ____ N ____
If yes, please attach information about these CEU courses.

Populations Treated

Adults ____ **Adolescents** ____ (Age ____ to ____) **Children** ____ (Age ____ to ____)
Couples ____ **Families** ____ **Geriatrics** ____
Group(s) Composition: _____

Assessments/Testing Provided

____ Psychological Testing ____ Drug & Alcohol ____ Neurological
 ____ D.O.T. Evaluations ____ Psychopharmacology ____ Disability Evaluation
 ____ Workers Comp/Disability ____ Learning Disorders ____ Crisis Intervention
 ____ Forensics ____ ADHD/ADD

M.H. Consultants is always looking for network providers to present at our biannual network provider meetings. If you are interested in presenting, please indicate below and briefly describe your proposed presentation topic for consideration. ____ **Yes, I am interested in presenting.**

Description of presentation:

Education

Please list all colleges/universities attended in chronological order with most recent listed first.

Name	Location (City, State)	Degree Awarded	Year Graduated

If you are a Psychiatrist, please indicate where your residency was completed:

License Information (Please attach copies)

Type of License : _____ (MD, Psychologist, LCSW, LPC, etc.)

Please, list ALL States in which you are licensed: (Include DEA and CDS where applicable)

Year Received	License Number	State	Expiration Date

Professional Certifications (Please attach copies)

Type	Year Received

How many years of post-graduate experience do you have? _____

M.H. Consultants, Inc.
Provider Network Membership Application

Do you have any relevant teaching experience:

Are there any relevant training/workshops that you have participated:

Other Professional Activities

If your vitae does not already indicate so, please attach additional information about major professional offices you have held, or committees on which you have served during the last 5 years.

Professional Affiliations

Inpatient Facilities:

Name	Location (City, State)

Professional Organizations:

Name

PPOs, HMOs, EAPs (Please attach additional sheet if you need more room):

Name

****If you are a Keystone Provider please make sure that you indicate this above.***

Professional Liability Insurance Information (Please attach copy of liability coverage page)

Name of Insurance Company: _____

Policy Number: _____

Total amount of coverage: \$_____M/\$_____M (Include CAT fund information)

(Minimum of \$1 Million/\$3 Million to qualify for membership in M.H. Consultants Network)

Expiration Date: _____

Have you ever been denied coverage (either initial or renewal) by any professional liability insurance carrier?

Yes _____ No _____ If Yes, please explain:

Have you had any malpractice judgments against you, made any settlements or have any pending cases against you? Yes _____ No _____ (If yes, please complete Professional Liability Case Report section below)

Involvement in professional liability actions and/or settlements does NOT disqualify you from participation. The information is sought as part of the overall credentialing process.

M.H. Consultants, Inc.
Provider Network Membership Application

Professional Liability Case Report (if applicable)

Date of Occurrence: ____/____/____ Name of Carrier: _____

What are (were) the specific allegations by the plaintiff?

Provide specific clinical details of the case as they occurred.

Were you the only defendant? ____ Yes ____ No
 If yes, were you the ____ Primary defendant ____ Codefendant ____ Other _____

Please list all other defendants and their roles in the case:

Please detail subsequent events including patient outcome:

Describe the current status of the case: ____ Pending

Additional Information:

Amount reserved by carrier for this case \$ _____
 ____ Closed without payment
 ____ Settled Date settled: ____/____/____ Amount of settlement \$ _____

What percent of the settlement was your and/or your carrier's responsibility? \$ _____

Disciplinary Actions

Have any of the following ever been, or are currently, in the process of being denied, revoked, suspended, reduced, limited, placed on probation, not renewed, voluntarily relinquished, or have you ever withdrawn, or failed to proceed with, an application for any of the following?

License in any State:	Yes ____ No ____
Other health related professional registration or license:	Yes ____ No ____
Academic appointment:	Yes ____ No ____
Other institutional affiliation, status and/or privileges:	Yes ____ No ____
Health related professional society membership/ fellowship certification:	Yes ____ No ____
Any other type of professional sanction:	Yes ____ No ____
Medicare, Medicaid, other third-party payors:	Yes ____ No ____
Convicted of (or pleaded no contest to) any criminal charges (other than motor vehicle violations) brought against you:	Yes ____ No ____
Convicted of (or pleaded no contest to) a drug or alcohol related offense?:	Yes ____ No ____

If you answered YES to any of these questions, please provide full explanation on a separate sheet, including resolution of any charges.

M.H. Consultants, Inc.
Provider Network Membership Application

Health Status

If the answer is YES to any of the following questions, please provide a full explanation on a separate sheet of paper.

Do you **presently** have a physical or mental health condition, including alcohol or drug abuse, that affects, or that may reasonably be expected to progress within the next two years to the point of affecting your ability to practice, or place your patients at increased risk?

Yes _____ No _____

Have you ever had any such condition in the past that is now resolved without the need for continuing therapy or medications?

Yes _____ No _____

Are you **currently** taking any medications or are you under any other type of therapy for a condition that could affect your ability to perform professional duties if the medication and/or therapy were discontinued today?

Yes _____ No _____

Have you at any time during the last 10 years been hospitalized or received any other type of institutional care for any such condition or problem?

Yes _____ No _____

When was your most recent physical examination: Date ____/____/____

Performed by: _____

Please list any significant findings: _____

M.H. Consultants, Inc.
Provider Network Membership Application

Conditions of Application

By applying for appointment as a Participating Provider of the M.H. Consultants network, I hereby:

- acknowledge that I, as an applicant for membership in the M.H. Consultants network, need to produce adequate information for a proper evaluation of my professional, ethical and other qualifications, for membership and for resolving any doubts about such qualifications;
- pledge to maintain an ethical practice, to provide for continuous care for my patients, and to refrain from delegating the responsibility for any aspect of the care of my patients to any practitioner not qualified to undertake that responsibility;
- authorize M.H. Consultants, its Medical Director and their representatives to consult with prior and current associates and others who may have information bearing on my professional competence, character, health status, ethical qualifications, ability to work cooperatively with others, and other qualifications to be, and continue to be, a Participating Provider in the M.H. Consultants network;
- consent to the inspection by M.H. Consultants, its Medical Director and their representatives of all documents that may be material to an evaluation of my qualifications and competence and consent to the release of such information. I hereby release from liability M.H. Consultants, its officers, directors, employees and agents for their acts performed and statements made in good faith and without malice, in connection with evaluating my application, my credentials and qualifications. In addition, I hereby release and any all individuals and organizations who provide information to M.H. Consultants, its Medical Director and their representatives in good faith and without malice, concerning my professional competence, background, experience, ethics, character, utilization practice patterns, health status and other qualifications to be a Participating Provider in the M.H. Consultants network. I am aware that the release from liability is an express condition to my application for, and acceptance of, membership in the M.H. Consultants network, and the continuation as a Participating Provider in the M.H. Consultants network;
- signify my willingness, if necessary, to appear for interviews in regard to my application;
- acknowledge that any material misstatements in, or omissions from, this application, constitute cause for denial of membership in the M.H. Consultants network or cause for summary dismissal from the M.H. Consultants network;
- recognize that the application process is a continuous process, that M.H. Consultants will credential and continuously re-credential me, and that the authorizations, acknowledgments, consents, pledges and releases provided in this application will remain in effect for purposes of credentialing and re-credentialing, until revoked by me in writing;
- submission of this application is not an assurance of acceptance in the M.H. Consultants network and if I am not accepted, it is not a reflection on the quality of my practice.

All information submitted by me in this application is true and complete to the best of my knowledge and belief. A photo static copy of this original statement constitutes my written authorization and request to release any and all documentation relevant to this application. Such photo static copy shall have the same force and effect as the signed original.

____/____/____
DATE

PRINTED NAME

SIGNATURE