Mental Health Consultants Inc. (MHC)

PROVIDER MEMBERSHIP APPLICATION

This form **must** be **Typed or Printed clearly** in entirety. You are required to **Include ALL attachments requested.**

Sign and Return to: **M.H. CONSULTANTS-** 2500 York Rd. Suite 110 Jamison PA 18929

✓ 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, must include ECFMG- Foreign Medical Graduate Certificate**

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APPLICANT:

***NAME** ______________________________ **DEGREE** __________ **TYPE** of License __________
(MD, Psychologist, SW, LPC, etc)

Group/Professional Name ______________________________ = TAX ID# ______________

Social Security Number ________________ Date of Birth __________

***PRIMARY OFFICE** Address: ____

City ______________________ State _____ Zip ________ COUNTY: ________________

Office Phone (_____)______________ Fax (_____)_____________ Other (____)_____________

Email address: ____________________________

Describe office setting: ____

____

Accessible for: Handicapped? Y ____ N ____ Transportation? Y ____ N ____

LIST ALL ZIP CODES you service within a 15 mile radius of your office ______________________________

____

***ADDITIONAL OFFICES**:

ENTITY & Tax # ***If different from above***: ____

(1) ______________________________________ City ________________ State ___ Zip ________

COUNTY: ________________ Phone: (_____)__________ Fx: (_____)__________

ENTITY & Tax # ***If different from above***: ____

(2)______________________________________ City ________________ State ___ Zip ________

COUNTY: ________________ Phone: (_____)__________ Fx: (_____)__________

(If additional locations or information, attach a separate sheet)

***DO YOU HAVE:**

- Office Manager/Admin? YES ___ NO ___ NAME ________________________ Phone: ____________
- Billing person? YES ___ NO ___ NAME ________________________ Phone: ____________
- Medical supervisor? YES ___ NO ___ NAME ________________________ Phone: ____________

***AFTER HOURS / EMERGENCY** COVERAGE arrangements (Include Names and Numbers):

____ PPO member? Y ______ N ________

____ PPO member? Y ______ N ________

CLINICAL SERVICES PROVIDED

PLEASE CHECK (√) ALL AREAS Provided

* **ALSO-** Indicate areas of: **CERTIFICATION as = C** **SPECIALIZATION as = S**

AREAS of TREATMENT

TREATMENT AREAS

ADJUSTMENT DISORDERS
___ Loss/Grief
___ Family changes
___ Legal issues
___ Medical/Chronic illness issues
___ Geriatrics

ADDICTIONS
___ Alcohol
___ Drug
___ Gambling
___ Dual Diagnosis
___ Smoking
___ Other __________

WORK ISSUES
___ Career Counseling
___ Employment issues

___ PSYCHOTIC DISORDERS

PERSONALITY DISORDERS
___ Explosive personality
___ Borderline personality
___ Dependent personality
___ Obsessive Compulsive DO
___ Narcissistic personality
___ Dissociative DO (MPD)

LEARNING DISORDERS
___ ADD/ADHD
___ Mental Retardation
___ Cognitive DO
___ Conduct DO
___ Head Trauma

EATING DISORDERS
___ Over eating
___ Bulimia/Anorexia

___ SLEEP DISORDERS

ANXIETY DISORDERS
___ Agoraphobia
___ Panic Disorder
___ Post Traumatic Stress DO

SEXUAL
___ Gender identity
___ Homo/Bi-Sexuality
___ Dysfunction

MOOD DISORDERS
___ Manic/ Bipolar
___ Depression

ABUSE
___ Sexual = ___Victim ___Perpetrator
___ Physical = ___Victim ___Perpetrator
___ Emotional= ___Victim ___Perpetrator

OTHER ISSUES
___ Marital ___ Paramour
___ Family
___ Parenting

LIST any treatment areas or populations you prefer **NOT** working with: ____

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POPULATIONS TREATED

ADULTS ____ ADOLESCENTS ___ (age ___ to ___) CHILDREN ___ (age ___ to ___) FAMILIES ____ COUPLES ____

GROUPS _____ - Composition?____

INDICATE any treatment areas or populations you prefer **NOT** working with: ____

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ASSESSMENTS

Psychological Testing ____ Neurological ____ Workers Comp/Disability ____ Diagnostic ____ Learning DI /ADD /ADHD ____

Forensics ____ Drug & Alcohol ____ D.O.T. Evals ____ Psychopharmacology ____ Disability Evals ____ Crisis intervention ____

What is your Theoretical orientation & what therapeutic techniques do you utilize?_______________________________________

____

Is there a *particular* theoretical perspective you are trained in & utilize? ____

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OTHER ADJUNCTIVE SERVICES AVAILABLE (i.e.: biofeedback, hypnotherapy/hypnosis, Spiritual guidance, relaxation therapy)

____

Please list any of **your** non-English languages: ____

If you wish to Present an MHC In-Service Training at one of our meetings, list you Presentation Topic/s for consideration:

____

EDUCATION

Name / Location **Degree Awarded** **Year Graduated**

College/University of *conferring / Primary* degree:

1____________________ ____________________ __________ ________

2____________________ ____________________ __________ ________

Residency *(Psychiatrist)*

____________________ ____________________ __________ ________

LICENSE INFORMATION

(ATTACH COPIES)

TYPE of PROFESSIONAL LICENSE: ((MD, Psychologist, SW, 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

(ATTACH COPIES)

Type	Year Received

Years of *Post* Graduate experience ____________

Teaching Experience (describe)______________________________

Other Training ______________________________

PROFESSIONAL AFFILIATIONS

ARE YOU A KEYSTONE PROVIDER? Yes ________ No ________

In-Patient facilities: *(Include location)*

Professional Organizations:

Other PPO's/ HMO's:

PROFESSIONAL LIABILITY INSURANCE INFORMATION (ATTACH copy of Liability Coverage Page)

Insurance Company ____

Policy Number ____________________________

Total amount of Coverage $_________m/ $__________m (**include** CAT Fund information)
MUST carry a minimum of 1/3million to qualify for membership

Expiration Date ____________________________

If you are self-insured, please attach an actuarial analysis of the financial stability of your plan.

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 of have any pending cases against you? YES____ NO____

If YES, please provide background information of all cases and settlements on a separate sheet of paper, including the state, court and jurisdiction of any claims.

It should be noted that 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.

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/license YES ___ NO ___

Academic Appointment YES ___ NO ___

Other institutional affiliation / status / 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.

HEALTH STATUS

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

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 medication/under other therapy for a condition that could affect your ability to perform professional duties if the medication/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/problem? YES ___ NO ___

Most recent physical examination: Date ____/____/____

Performed by: ____

Significant findings:

____

____

____

OTHER PROFESSIONAL ACTIVITIES

Attach your current bibliography to this application, including major professional offices you have held, or committees on which you have served during the last 5 years, and continuing education programs/courses attended or participated in, since completion of your graduate medical training, or during the last 2 years.

YOUR UCR (Retail Rates)

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

"YOUR" Office Hours (Hours available for Patient Care)

	PRIMARY LOCATION:	OTHER LOCATION (1):	OTHER LOCATION (2):	OTHERS:
Monday	________________	____________________	______________________	________________________
Tuesday	________________	____________________	______________________	________________________
Wednesday	________________	____________________	______________________	________________________
Thursday	________________	____________________	______________________	________________________
Friday	________________	____________________	______________________	________________________
Saturday	________________	____________________	______________________	________________________
Sunday	________________	____________________	______________________	________________________

OTHER PERTINANT INFORMATION: ____

____

____

CONDITIONS OF APPLICATION

By applying for appointment as a Participating Provider of the MHC network, I hereby:

- acknowledge that I, as an applicant for membership in the MHC 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 MHC, 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 MHC network;
- consent to the inspection by MHC, 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 MHC, 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 MHC, 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 MHC network. I am aware that the release from liability is an express condition to my application for, and acceptance of, membership in the MHC network, and the continuation as a Participating Provider in the MHC 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 MHC network or cause for summary dismissal from the MHC network;
- recognize that the application process is a continuous process, that MHC 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 MHC 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**