MHC PROVIDER RE-CREDENTIALING FORM

To complete this form online, please visit us at www.mhconsultants.com

or

Mail to MHC: 1501 Lower State Rd., Bldg. D, Suite 200, North Wales, PA 19454

Phone: 215-343-8987; Fax: 215-343-8983

Include all of the following documents:

* State License(s) (Psychiatrists and registered nurses must include DEA license)
* Face Sheet of Professional Liability Insurance (include CAT Fund information if applicable)
* Current W9 Form
* Copies of all Professional Certifications earned during the last two years (optional)
* Copy of highest degree received (if changed)

Questions or concerns regarding this form should be directed to MHC' Provider Relations, 215-343-8987, ext. 1201.

****

PROVIDER DEMOGRAPHIC INFORMATION

Last Name _____ First _____ MI _____

Nickname _____

Professional Organization/Practice Name_____
(contracted with MHC) (as listed on your W9 Tax Form)

Federal Tax ID#_____ Individual NPI # _____

License Type: (*Check one*)
○ Counselor ○ Psychologist ○ Medical
○ Social Worker ○ Registered Nurse

- Primary Office Address

  Address_____Suite_____

  City _____ County _____ State _____ ZIP _____

  ○ My primary office is in my home (check if applicable)

  Handicapped Accessible ○ **Yes** ○ **No** Public Transportation ○ **Yes** ○ **No**

  Phone Number_____ext_____ Fax Number_____

- Secondary Practice Address Under This Tax ID# *(if MHC has a secondary location on file and you do not confirm it here, we will assume you no longer see patient's at this location and will inactivate it in our database)*

  Address_____Suite_____

  City _____ County _____ State _____ ZIP _____

  ○ My secondary office is in my home (check if applicable)

  Handicapped Accessible ○ **Yes** ○ **No** Public Transportation ○ **Yes** ○ **No**

  Phone Number_____ext_____ Fax Number_____

Provider's Email Address _____

Office Manager's Name _____ Phone ext._____

Office Manager's Email Address_____

- Primary Mailing Address_____
- Payment Address_____

How do you prefer to receive information? *(Check all that apply)* ○ Mail ○ Email ○ Fax

Emergency Phone Number/Procedures_____

Please check all of these insurances accepted:

○ Blue Cross/Blue Shield
○ Cigna
○ Keystone
○ Personal Choice
○ Aetna

TREATMENT AREAS

Please check all of the services you provide and complete the section below as detailed as possible. This will assure that we are offering referrals that will be a perfect match based on the needs of our patients.

- ○ ADD/ADHD
- ○ Agoraphobia
- ○ Alcohol Dependency- Active
- ○ Alcohol Dependency- Recovering
- ○ Anger Management
- ○ Anxiety/Panic
- ○ Bipolar Disorder
- ○ Chemical Dependency- Active
- ○ Chemical Dependency- Recovering
- ○ Compulsive Gambling
- ○ Conduct Disorder
- ○ Cultural/Ethnic Issues
- ○ Depressive Disorders
- ○ Developmental Disorder Assessments
- ○ Disability Assessments
- ○ Divorce/Blended Family
- ○ Domestic Violence
- ○ D.O.T. Assessments
- ○ Drug & Alcohol Assessments
- ○ Dual Diagnosis
- ○ EAP Critical Incident Response
- ○ EAP Workshops/Seminars
- ○ Eating Disorders
- ○ Emotional Abuse- Perpetrator
- ○ Emotional Abuse- Victim
- ○ Fitness-for-Duty Assessments
- ○ Forensic Assessments
- ○ Grief/Loss
- ○ Groups
- ○ Head Trauma
- ○ HIV/AIDS Related Issues
- ○ Learning Disorder Assessments
- ○ Medical/Chronic Illnesses
- ○ Obsessive Compulsive Disorder
- ○ Pain Management
- ○ Personality Disorders
- ○ Physical Abuse- Perpetrator
- ○ Physical Abuse- Victim
- ○ Prenatal/Postpartum Issues
- ○ Psychological Assessments
- ○ Psychopharmacology Assessments
- ○ Psychotic Disorders
- ○ PTSD
- ○ Neurological Assessments
- ○ Sexual Abuse- Perpetrator
- ○ Sexual Abuse- Victim
- ○ Sexual Disorders
- ○ Spirituality
- ○ Stress Management
- ○ Workers Compensation Assessments

If you conduct groups, please list Group Composition_____

_____

Clinical Orientation and Areas of Specialty *(not listed in treatment areas above)*_____

_____

Other Training and/or Professional Certifications_____

_____

_____

Other Services Provided (*Check all that apply)*

- CID
- D&A Assessments
- SAP

Age Groups Treated *(Check all that apply)*

- Children 1-9
- Children 10-12
- Adolescents 13-19
- Adults

Languages Therapy Conducted In *(other than English)*_____

DISCIPLINARY ACTIONS

Have you ever been disciplined, excluded from, debarred, suspended, reprimanded, sanctioned, censured, disqualified, subject to a recovery action, or otherwise restricted in regard to participation in the Medicare or Medicaid programs, or in regard to any federal or state governmental health care plans or programs? ○ **Yes** ○ **No**

If yes, please provide a full explanation on a separate sheet including the final resolution and submit it with this form.

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**
✓ DEA / controller dangerous substances registrations(s)	○ **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**
✓ Any third party payers	○ **Yes**	○ **No**
✓ Been convicted of, or pleaded no contest, to any criminal charges (other than motor vehicle violations) brought against you?	○ **Yes**	○ **No**
✓ Been 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 and submit it with this form.

HEALTH STATUS

Are you able to perform all of the services required by the applicable provider agreement, with or without reasonable accommodation, according to the accepted standards of professional performance and without posing a direct threat to the safety of patients? ○ **Yes** ○ **No**

Do you presently have a physical or mental health condition, including alcohol or drug abuse, which affects, or that may reasonably be expected to progress within the next two years to the point of effecting your ability to practice, or place your patients at increased risk? ○ **Yes** ○ **No**

If the answer is **YES,** please provide a full explanation on a separate sheet.

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

_____

PRINTED NAME

_____ ___/___/___

SIGNATURE **DATE**

ADDITIONAL ORGANIZATION INFORMATION

This page is to confirm your demographic information for each additional organization (**different Federal Tax ID#**) under contract with MHC. Please make copies as needed. If you are no longer practicing at additional organizations, please inform us. Do not complete this section if you do not practice under more than one Tax ID#.

Professional Organization/Practice Name _____
(as listed on your W9 Tax Form)

Federal Tax ID#_____

- Primary Office

  Address_____Suite_____

  City _____ County _____ State _____ ZIP _____

  ○ My primary office is in my home (check if applicable)

  Handicapped Accessible ○ **Yes** ○ **No** Public Transportation ○ **Yes** ○ **No**

  Phone Number_____ext_____ Fax Number_____

- Secondary Practice Address *(if MHC has a secondary location on file and you do not confirm it here, we will assume you no longer see patient's at this location and will inactivate it in our database)*

  Address_____Suite_____

  City _____ County _____ State _____ ZIP _____

  ○ My secondary office is in my home (check if applicable)

  Handicapped Accessible ○ **Yes** ○ **No** Public Transportation ○ **Yes** ○ **No**

  Phone Number_____ext_____ Fax Number_____

Office Manager's Name _____ Phone ext._____

Office Manager's Email_____

- Primary Mailing Address_____
- Payment Address_____

How do you prefer to receive information? ○ Mail ○ Email ○ Fax
(Check all that apply)

Emergency Phone Number/Procedures_____

Please check all of these insurances accepted:

○ Blue Cross/Blue Shield ○ Keystone ○ Aetna
○ Cigna ○ Personal Choice