Behavioral Health Network Inc.
PROVIDER APPLICATION

Under what specialty do you choose to be listed in the directory? _____

A. General Information

Last Name	First Name	Middle Initial	Professional Designation or Title
Preferred Mailing Address Line 1		Preferred Mailing address Line 2	
City	State	Zip	Telephone
Social Security Number (**REQUIRED**)	Date of Birth **(REQUIRED)**	Sex	Provider Number

B. Primary Office Information

BEHAVIORAL HEALTH NETWORK, INC. Practice Name			# of years at this site
417 Liberty St Practice Address Line 1		Practice Address Line 2	
Springfield City	***MA*** State	***01104*** Zip	***(413)-747-0705*** Contact Telephone
Teresa Becerra Contact:			***(413) 732-7075*** Fax Telephone

Make checks payable to (must match tax ID owner name on file with IRS for the EIN listed below			Type of Corporation
Behavioral Health Network, Inc. Billing Address Line 1	***P.O. Box 2738*** Billing Address Line 2		
City ***Springfield***	State ***MA***	Zip ***01101***	Telephone ***413-747-0705***
04-2103756 Employer Identification Number (EIN)	W-9 on file (*submit form if blank)*	***Y10246*** Your Medicare/UPIN Number	***110027780B*** Your Medicaid Number

Hours of Operation (actual practice hours each day at this location):

Monday		Tuesday		Wednesday		Thursday		Friday		Saturday	
From	To	From	To	From	To	From	To	From	To	From	To

Identify any foreign language(s) or sign language that you speak **fluently** in treating patients (select no more than 5)

☐ Arabic (AR)	☐ Chinese (CH)	☐ Farsi (FA)	☐ French (FR)	☐ German (GE)
☐ Hebrew (HE)	☐ Hindi (HI)	☐ Italian (IT)	☐ Japanese (JA)	☐ Korean (KO)
☐ Laotian (LA)	☐ Portuguese (PO)	☐ Russian (RU)	☐ Sign Language (SL)	☐ Spanish (SP)
☐ Vietnamese (VI)	☐ Tagalog (TA)	☐ Other (Specify):		

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C. Referral Information

Identify the percentage of your practice time dedicated to the following patient population and modality categories:

Population	% of Practice	Business Lines	% of Practice
Child (up to age 12)		Group Health (PPO)	
Adolescent (13-17)		Capitation (HMO)	
Adult (18-64)		Workers Compensation	
Geriatric (65+)		Personal Injury	

D. Additional Office Information

Practice Name			
Practice Address Line 1		Practice Address Line 2	
City	State	Zip	

Make checks payable to (must match tax ID owner name on file with IRS for the EIN listed below)			
Billing Address Line 1		Billing Address Line 2	
City	State	Zip	Telephone
Employer Identification Number (EIN)	W-9 on file (submit form if blank)	Your Medicare/UPIN Number	Your Medicaid Number

Hours of Operation (actual practice hours each day at this location):

Monday		Tuesday		Wednesday		Thursday		Friday		Saturday	
From	To	From	To	From	To	From	To	From	To	From	To

Is this Behavioral Health Network, Inc Yes_____ No_____ office handicapped accessible?

Is this Behavioral Health Network Inc. office to Yes_____ No_____ accessible to public transportation?

E. Referral Information for offices

Identify the percentage of your practice time dedicated to the following patient population and modality categories:

Population	% of Practice	Business Lines	% of Practice
Child (up to age 12)		Group Health (PPO)	
Adolescent (13-17)		Capitation (HMO)	
Adult (18-64)		Workers Compensation	
Geriatric (65+)		Personal Injury	

F. License Certification Information

Drug Certificate: If applicable, list below your current DEA/CD's Certificate Number and expiration date.

DEA Certificate #	Exp. Date

CDS Certificate #	Exp. Date

PROFESSIONAL LICENSE(S) List below your current professional license(s). to expedite credentialing, submit a copy of your current state license.

Board Name	Certificate #	Cert. Date	Exp. Date

G. Malpractice Insurance

List below your current malpractice carrier. Enclose a copy of your current policy certificate and/or declarations page showing the coverage limits and dates of coverage.

Current Carrier	Policy Number	Dates of Coverage	Coverage Limits
ACORD w/Chase, Clarke, Stewart & Fontana Mutual Ins. Agency	***PHPK2216079***	***01/01/21 – 01/01/22***	***EA CL $1,000,000.00 AGGRE $3,000,000.00***

In the space provided below, list the name and address of the malpractice carrier who has provided coverage for you for the most recent five (5) year period. **If there has been more than one carrier, please indicate the dates of coverage with each carrier, and the reason for changing carriers.**

Carrier (Name and Address)	Policy Number	Dates of Coverage	Reason for Changing Carriers
		-	
		-	
		-	

H. Education Information

Educational Institution (include name and complete address)	Degree	From (mm/yy)	To (mm/yy)
Undergraduate			
Graduate/Medical School			
Internship			
Residency			
Fellowship			

If you are a foreign medical school graduate, are you certified by the Education Commission for Foreign Medical Graduates (ECFMG)? ☐ Yes ☐ No

Continuing Education: List any continuing education seminars/workshops you have attended in the past 24 months. Please attach copy of CEU certificate(s) of completion or you may attach a copy of your Accredited Continuing Education Agency's Report, if applicable.

Course Subject	Sponsoring Organization (Name and Address)	Date Completed (mm/dd/yy)	# of CEUs awarded

BOARD CERTIFICATION/SPECIALTY: List below any current board certifications.

Board Name	Certificate #	Cert. Date	Exp. Date

I. Work History

List below all work history for a five (5) year period beginning with the current. **Please explain fully any gaps of six months or more on a separate sheet of paper.** A current Curriculum Vitae (must specify month and year) may be submitted.

From (Month/Year)	To (Month/Year)	Description of Activities
	Present	**Behavioral Health Network, Inc., 417 Liberty St., Spfld., MA 01104**

J. HOSPITAL PRIVILEGES

List below, if applicable, current hospital privileges.

Primary Admitting Facility	Address	Type of Privilege

Other Hospital Privileges	Address	Type of Privilege

CALL COVERAGE: Each practitioner providing care for Behavioral Health Network, Inc. members must arrange for 24-hour coverage. Identify your coverage practitioner(s) by name. It is strongly preferred that your covering practitioner(s) also participate in the Behavioral Health Network, Inc. network. If not, services performed in your absence are subject to the terms of the Participating Practitioner Agreement. **After hours at BHN, all calls default to "BHN Crisis & Support Services" available 24/7.**

Call Coverage Practitioner	Licensure Level	Telephone
Call Coverage Practitioner	Licensure Level	Telephone
Call Coverage Practitioner	Licensure Level	Telephone

ANSWERING SERVICE: Indicate how you can be reached after hours:

Answering Service Name	Phone #

Beeper #	Voice Mail #

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K. Attestation

NOTE: If "**YES"** is checked**, please explain fully** on a separate sheet. Documentation is required if you have malpractice claims pending or settled in the past five (5) years (include any settlements/adjudication's, original complaint and final disposition). Your signed statement regarding the alleged incident will suffice for pending cases.

1. **Health Status:** Do you currently have any physical, mental, or emotional condition which may impair your ability to render the professional services which are the subject of this application…….. ☐ Yes ☐ No
   a. Do Currently use illegal drugs or abuse drugs or alcohol?…….. ☐ Yes ☐ No
2. **Insurance Coverage:** Do you currently have malpractice insurance coverage?…… **X** Yes ☐ No
   a. Has your professional liability insurance coverage ever been denied, canceled, or non-renewed or Initially refused upon application?…… ☐ Yes ☐ No
3. **License**: Has your medical or professional license in any sate ever been revoked, suspended, placed On probation, conditional status, or limited?…….. ☐ Yes ☐ No
   a. Have you ever voluntarily surrendered your license?…… ☐ Yes ☐ No
   b. Are formal charges pending against you at this time?…… . ☐ Yes ☐ No
4. **DEA:** Has your DEA Registration Certificate ever been suspended, revoked, subjected to probation, placed on Conditional status, or limited**?**…… ☐ Yes ☐ No
5. **Hospital Privileges:** Has any hospital ever dismissed you from its staff?…… ☐ Yes ☐ No
   a. Has any hospital ever revoked, suspended, or limited your privileges?…… ☐ Yes ☐ No
   b. Has any hospital initiated either type of aforementioned action by formal notice to you?…….. ☐ Yes ☐ No
   c. Has any hospital refused or denied you privileges?…….. ☐ Yes ☐ No
   d. Have you ever voluntarily surrendered your hospital privileges……. ☐ Yes ☐ No
6. **Hospital Sanctions:** Have you ever surrendered your clinical privileges upon threat of censure, restriction suspension or revocation of such privileges?…….. ☐ Yes ☐ No
7. **Professional Membership(s):** Has your membership in any professional society or association ever been canceled, revoked, or censured?…… …☐ Yes ☐ No
8. **Medicare/Medicaid:** Have you ever been fined, has an arrangement suspended, been expelled from Participation or had criminal charges brought against you by Medicare or Medicaid?…… ☐ Yes ☐ No
9. **Criminal Offenses:** Have you ever been convicted of a felony or involved in charges relating to moral or Ethical turpitude?…….. ☐ Yes ☐ No
   a. Have you ever been named as a defendant in any criminal proceeding?…… … ☐ Yes ☐ No
10. **Board Discipline:** Have you ever been the subject of disciplinary proceedings by any professional Association or organization (i.e., state licensing board; county; state or national professional society, hospital medical or clinical staff)?……. ☐ Yes ☐ No
11. **Malpractice Action:** Has any malpractice action against you been brought or settled in the last 5 years or has there been any unfavorable judgment(s) against you in a malpractice action?…….. ☐ Yes ☐ No
    a. To your knowledge, is any malpractice action against you currently pending?…….. ☐ Yes ☐ No

I hereby attest that the information above is true and correct.

_____ _____

Signature Date (mm/dd/yy)

PARTICIPATION STATEMENT

I fully understand that if any matter stated in this application is or becomes false, Behavioral Health Network, Inc. will be entitled to terminate my provider agreement for breach. All information submitted by me in this application is warranted to be true, correct and complete.

I authorize Behavioral Health Network, Inc. and/or its Credentials Verification Organization (CVO) to consult with the National Practitioners Data Bank, state licensing board(s), educational institutions, specialty boards, malpractice insurance carriers, Educational Council for Foreign Medical Graduates, hospitals, professional references and any other person or entity from whom/which information may be needed to complete the credentialing process or to obtain and verify information concerning my membership, professional competence, character and moral and ethical qualifications, and I also authorize all of them to release such information to Behavioral Health Network, Inc. and/or its CVO. I release Behavioral Health Network, Inc. and its employees and/or its CVO and all those whom Behavioral Health Network, Inc. and/or its CVO contracts from any and all liability for their acts performed in good faith and without malice in obtaining and verifying such information and in evaluating my application.

I consent to the release by any person to Behavioral Health Network, Inc. and/or its CVO of all information that may reasonably be relevant to an evaluation of my professional competency, character and moral ethical qualification, including any information relating to any disciplinary action or suspension or curtailment of privileges, and hereby release any such person providing such information from any and all liability for doing so.

I understand that Behavioral Health Network is required to credential and recredential physicians and other health care providers in accordance with applicable regulatory requirements, the requirements imposed on the Agency by the Department of Medical Assistance, and by the requirements imposed by payors who have delegated their credentialing process to Behavioral Health Network. I give my permission for these regulators and payors to access the information required for credentialing and recredentialing purposes.

I understand that Behavioral Health Network does not withhold credentialing based on race, ethnicity, gender, religion, age, sexual orientation, disability, or income level.

_____ Date(mm/dd/yy): _____
Signature of Applicant

_____
Name (Please Print)

RETURN COMPLETED APPLICATION TO:
Behavioral Health Network, Inc.
Attn: Teresa Becerra
417 Liberty St
Springfield, MA 01104
Tel. 413-747-0705
Fax 413-732-7075
Submit via E-mail

REQUIRED DOCUMENTATION TO ACCOMPANY THIS APPLICATION

- **COPY OF CURRICULUM VITAE (*Must be in Month/Year format, displaying a minimum of 5 years work history*)**
- **COPY OF CURRENT STATE LICENSE & HIGHEST DEGREE OBTAINED**
- **COPY OF CURRENT STATE CONTROLLED DANGEROUS SUBSTANCE (CDS) CERTIFICATE**
- **COPY OF CURRENT FEDERAL DRUG ENFORCEMENT AGENCY (DEA) CERTIFICATE & MA CONTROLLED**
- **COPY OF CURRENT MALPRACTICE INSURANCE FACE SHEET**