

Behavioral Health Preliminary Provider Information Form



Preliminary forms will not be reviewed unless accompanied by a resumé or CV. Please complete all sections. (This is not an application.)

Name of provider		
Type of practice	<input type="checkbox"/> Private practice <input type="checkbox"/> Group practice <input type="checkbox"/> Facility <input type="checkbox"/> Located in a Federally Qualified Health Center (FQHC)	
Name of practice/facility		
Demographics	Street address: City and Zip: County: Telephone: Secure Fax: E-mail address: Website:	
Office hours: (day and times)	<input type="checkbox"/> M: _____ <input type="checkbox"/> Tu: _____ <input type="checkbox"/> W: _____ <input type="checkbox"/> Th: _____ <input type="checkbox"/> F: _____ <input type="checkbox"/> Sat: _____ <input type="checkbox"/> Sun: _____	
Briefly describe your after-hours coverage arrangements:		
How long have you been at this practice/facility? Years _____ Months _____	Are you located in a primary care physician's office? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, PCP's name:	If no, describe your access to medication management services for your patients:	
What is your location office setting? <input type="checkbox"/> Traditional <input type="checkbox"/> Non-traditional (church, private residence, non-related business, etc.)	If setting is non-traditional, describe the location:	
Do you have experience working with managed care organizations? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Have you previously had a contract with Priority Health? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain briefly:		
What accreditation(s) do you currently hold? <input type="checkbox"/> CARF <input type="checkbox"/> COA <input type="checkbox"/> JCAHO		
What Priority Health products are you interested in participating with? <input type="checkbox"/> HMO <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> PPO		
Are you willing to participate with case reviews as required? <input type="checkbox"/> Yes <input type="checkbox"/> No		

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Average number of sessions that you typically see an individual for treatment:	
Do you have quality improvement measures in place? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, briefly describe the measures:	
Describe briefly how you would measure customer satisfaction:	
Check all services/specialties that you are qualified to provide to Priority Health members: (Additional documentation may be requested)	
<input type="checkbox"/> ADD/ADHD testing** <input type="checkbox"/> Borderline personality disorder <input type="checkbox"/> Chemical dependency <input type="checkbox"/> Cultural/ethnic issues <input type="checkbox"/> Dialectical behavior therapy (DBT) <input type="checkbox"/> Domestic violence <input type="checkbox"/> Dual diagnosis <input type="checkbox"/> Eating disorders <input type="checkbox"/> EMDR <input type="checkbox"/> Gay/lesbian issues <input type="checkbox"/> Grief issues <input type="checkbox"/> Hearing impaired* <input type="checkbox"/> Medical co-morbidities * Requires ability to sign ** Requires Doctorate-Level with Full Licensure	<input type="checkbox"/> Mental health <input type="checkbox"/> Neuropsych testing** <input type="checkbox"/> Phobias <input type="checkbox"/> Psychological testing ** <input type="checkbox"/> Post-traumatic stress disorder <input type="checkbox"/> Psychosomatic issues <input type="checkbox"/> Sexual trauma <input type="checkbox"/> Terminal illness <input type="checkbox"/> Children (0-5) <input type="checkbox"/> Children (6-12) <input type="checkbox"/> Adolescents (13-17) <input type="checkbox"/> Adults (18-62) <input type="checkbox"/> Geriatric (65 +)
List state license(s):	List certification(s):
List highest clinical degree:	Ethnicity (optional):
List languages other than English that you speak fluently:	

Applications packets will be sent based on business need to meet access and availability standards for our members.

Signature: _____ Date: _____

Return completed form to:
 Priority Health, Behavioral Health Department
 Attn: Provider Services, MS 2310
 1231 East Beltline NE
 Grand Rapids, MI 49525

Fax: 616 942-7992