

# Behavioral Health Supplemental Form

Full name \_\_\_\_\_

Type of practice:     Private practice     Group practice  
                                  Facility                                    Located in a Federally Qualified Health Center

Name of practice/facility \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_ County \_\_\_\_\_

Phone # \_\_\_\_\_ Secure fax # \_\_\_\_\_

Email address \_\_\_\_\_ Website \_\_\_\_\_

Office hours:     Mon. \_\_\_\_\_     Tues. \_\_\_\_\_     Wed. \_\_\_\_\_     Thurs. \_\_\_\_\_     Fri. \_\_\_\_\_  
                          Sat. \_\_\_\_\_     Sun. \_\_\_\_\_

Explain your policy for after-hours coverage:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

How long have you been at this practice/facility? Years \_\_\_\_\_ Months \_\_\_\_\_

Are you located in a primary care physician's office?

Yes. PCP name \_\_\_\_\_

No. Describe your access to medication management services for you patients. \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

What is your location/office setting?

Traditional  
 Non-traditional (church, private residence, non-related business) \_\_\_\_\_

\_\_\_\_\_

Do you have experience working with a health benefits company?

Yes                     No

Have you previously had a contract with Priority Health?

No  
 Yes. Explain \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**What accreditation(s) do you currently hold?**

- CARF     COA     JCAHO     NONE

**Professional interests**

(Mental health services include treatment for anxiety, depression and crisis intervention)

- |   |   |
|---|---|
| <input type="checkbox"/> Borderline personality       | <input type="checkbox"/> Other languages                |
| <input type="checkbox"/> Cultural/ethnic issues _____ | <input type="checkbox"/> Phobias                        |
| <input type="checkbox"/> Domestic violence            | <input type="checkbox"/> Post-traumatic stress disorder |
| <input type="checkbox"/> Co-occurring disorder        | <input type="checkbox"/> Psychosomatic issues           |
| <input type="checkbox"/> Eating disorders             | <input type="checkbox"/> Sexual trauma                  |
| <input type="checkbox"/> Gay/lesbian issues           | <input type="checkbox"/> Terminal illness               |
| <input type="checkbox"/> Grief issues                 | <input type="checkbox"/> Other _____                    |
| <input type="checkbox"/> Hearing impaired             |   |

**Testing / Procedures**

- ADD/ADHD (Criteria: Doctorate-level with full licensure)
- Psychological testing (Criteria: Doctorate-level with full licensure)
- EMDR (Criteria: Submission of certificate copy required)
- Neuropsychology (Criteria: Appendix L –Submission of training and work experience required)

Application packets will be sent based on business need to meet access and availability standard for members.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**Return completed form to:**

Priority Health  
Attn: Behavioral Health/Provider Services, MS 2310  
1231 East Beltline NE  
Grand Rapids, MI 49525

Fax: 616 975-8851

**East Michigan providers return to:**

Priority Health  
Attn: Behavioral Health/Network Development, MS FH11  
34505 West Twelve Mile Road  
Farmington Hills, MI 48331

Fax: 248 324-2984