Behavioral Health Addendum
January 2008

NAME IN FULL: _____
Last First Middle Maiden *(if applicable)*

Fax number for authorizations: (_____)_____

Will you see Priority Health members in an office(s) that also serves another purpose, such as a residence or non-related business?
___ No ___ Yes (If yes, we will forward specific criteria to you.)

Are you an employee of a Federally Qualified Health Center (FQHC) or a Child and Adolescent Health Center (CAHC)?
___ No ___ Yes

Explain the arrangements you have for 24-hour, 7 days a week coverage for your patients:
_____

Your office address(es) and telephone number(s), as indicated on the Standard Practitioner Application, will be used in the Provider Directory at *priorityhealth.com*. You may also have the following included:

Special Awards/Honors/Certifications:_____

Hobbies/Interests: _____

SERVICES PROVIDED (✓ all that apply)
Indicate your preferred and/or specialty population for Priority Health members

- ☐ Infants/toddlers: Ages 0-5 _____ %
- ☐ Children: Ages 6-12 _____ %
- ☐ Adolescents: Ages 13-17 _____ %
- ☐ Adults: Ages 18-64 _____ %
- ☐ Geriatrics: Ages 65+ _____ %

PROFESSIONAL INTERESTS *(Mental Health Services include treatment for anxiety, depression, crisis intervention)*

- ☐ Borderline personality
- ☐ Hearing impaired
- ☐ Gay/lesbian issues
- ☐ Phobias
- ☐ Cultural/ethnic issues _____
- ☐ Grief issues
- ☐ Terminal illness
- ☐ Post-traumatic stress disorder
- ☐ Psychosomatic issues
- ☐ Other languages _____
- ☐ Other: _____

TESTING / PROCEDURE(S)

- ☐ ADD/ADHD (Criteria: Doctorate-level with full licensure)
- ☐ Psychological testing (Criteria: Doctorate-level with full licensure)
- ☐ ECT (Criteria: Physicians only)
- ☐ Neuropsychology (Criteria: Appendix L – Practitioner specific criteria)

SPECIALTY AREAS

- ☐ Domestic Violence
- ☐ Eating Disorders
- ☐ EMDR
- ☐ Sexual Trauma

To be identified as a provider in any of the above specialty areas, attach documentation for each specialty area selected:
a) Certification of continuing education or formal training, or
b) Documentation of appropriate work experience, or
c) *Published articles, research studies, or Society affiliation*

DUAL DIAGNOSIS ☐
To be identified as a provider in the specialty area of Dual Diagnosis, attach documentation:
a) Practitioners in a public or private firm, association, organization, or group offering or purporting to offer specific substance abuse treatment, rehabilitation, casefinding, or prevention services, must submit evidence that the facility or site at which the practitioner will provide substance abuse services is licensed (or granted exception) by the State of Michigan as a Substance Abuse Program.
b) Successful completion of a master's degree in social work or counseling;
c) CAC (Certified Addictions Counselor) credentials, minimum Level I; if not certified as an addictions counselor, provider must demonstrate all of the following:
  a. 3,000 hours of counseling experience, providing direct services to clients in substance abuse or related human services
  b. 135 hours of training or continuing education specific to alcohol and other drug abuse issues
  c. 150 hours of direct supervision
d) Services are provided in an underserved area
e) If recovering, at least three (3) years of continuing sobriety