



### Provider Specialty Profile

This profile was created to capture specific information that will allow us to improve our referral process by closely matching member needs with provider services.

#### Provider Information

**Name:** \_\_\_\_\_  
First Middle Last Suffix

**Licensure:** \_\_\_\_\_ **State of Licensure:** \_\_\_\_\_  
(MD, ARNP, PhD, LCSW, etc)

**E-Mail address (provider):** \_\_\_\_\_ **Website:** \_\_\_\_\_

**Primary Office Street Address:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

**County:** \_\_\_\_\_ **Phone:** \_\_\_\_\_ **Fax:** \_\_\_\_\_

*Please attach a separate sheet of paper listing your service sites if you have more than one location. Be sure to include information for each field.*

**Billing Office Contact Information:** \_\_\_\_\_  
Name Phone Email address

**Group Name/ Clinic Name (if applicable):** \_\_\_\_\_

**Medicaid #:** \_\_\_\_\_ **Medicare #:** \_\_\_\_\_

**NPI #:** \_\_\_\_\_ **Taxonomy Type:** \_\_\_\_\_

**Tax ID#:** \_\_\_\_\_

Are you currently accepting new members?  Yes  No

| Office Hours |  |
|--------------|--|
| MONDAY       |  |
| TUESDAY      |  |
| WEDNESDAY    |  |
| THURSDAY     |  |
| FRIDAY       |  |
| SATURDAY     |  |
| SUNDAY       |  |

**Appointment Availability:** Please indicate your availability for the following appointment types:

\* **Routine appointment** – within 10 business days (14 calendar days)  Yes  No

\* **Urgent appointment** – within 24 hours  Yes  No

\* **7-day Post Hospital Discharge appointment**  Yes  No *Please indicate location:*  In home  In office



**Ethnicity:** Please choose the option that best describes your ethnic background.

- American Indian or Alaskan Native       Asian or Pacific Islander  
 African America, Black       Hispanic or Latino  
 White, Non-Hispanic       Other: \_\_\_\_\_ (please specify)

**Do you provide services in languages other than English?**     Yes       No  
If "Yes," what other languages? \_\_\_\_\_

**Does your office staff speak languages other than English?**     Yes       No  
If "Yes," what other languages? \_\_\_\_\_

**Do you offer emergency services?**     Yes       No  
If "Yes," please describe: \_\_\_\_\_

**Do you provide services to the following populations?** (Check those that apply)  
 Serious Mental Illness (SMI)     Serious Emotional Disturbance (SED)     Severe Persistent Mentally Ill (SPMI)

**Are you able to provide services to any of the following special needs population?** (Check those that apply)  
 Deaf/ Hearing Impaired     Blind/ Vision Impaired     Developmental Disability  
 Physical Disability     Other (*please specify*): \_\_\_\_\_

**Are you Board Certified?**     Yes       No  
If "Yes," what type of Board Certification do you have? \_\_\_\_\_

**Do you have admitting privileges/ affiliations at a hospital?**     Yes       No  
If "Yes," please list the hospital(s) where you have privileges: \_\_\_\_\_  
\_\_\_\_\_

**Are the following areas in your office handicapped accessible?** (check those that apply)  
 Building     Restroom     Therapy Room     Parking

**What are your age restrictions?**    Youngest Age: \_\_\_\_\_    Oldest Age: \_\_\_\_\_

**Do you provide services to both males and females?**     Yes       No  
If "No," please explain: \_\_\_\_\_  
\_\_\_\_\_

**In which setting do you typically provide services?** (Check those that apply)  
 Traditional Outpatient     Community-Based     Mobile Crisis     School-Based  
 Nursing Home     Hospital-Based (In-pt Only)     Home-Based     Other \_\_\_\_\_



**Please select the types of services you offer, including the disorders you treat and the modalities you practice.**  
 (Check those that apply)

| Types of Services                |   |                          |                                       |
|----------------------------------|---|--------------------------|---------------------------------------|
| <input type="checkbox"/>         | Individual Therapy                      | <input type="checkbox"/> | Intensive Outpatient                  |
| <input type="checkbox"/>         | Couples Therapy                         | <input type="checkbox"/> | Psychological Testing                 |
| <input type="checkbox"/>         | Family Therapy                          | <input type="checkbox"/> | Neuropsychological Testing            |
| <input type="checkbox"/>         | Group Therapy                           | <input type="checkbox"/> | Other (please specify)                |
| <input type="checkbox"/>         |   | <input type="checkbox"/> |                                       |
| Treatment Modalities/ Approaches |   | Disorders/ Issues        |                                       |
| <input type="checkbox"/>         | ABA (Applied Behavior Analysis)         | <input type="checkbox"/> | ADD/ ADHD                             |
| <input type="checkbox"/>         | Biofeedback                             | <input type="checkbox"/> | Adjustment Disorders                  |
| <input type="checkbox"/>         | Client Centered Therapy                 | <input type="checkbox"/> | Anxiety Disorders                     |
| <input type="checkbox"/>         | Cognitive Behavioral Therapy            | <input type="checkbox"/> | Attachment Disorders                  |
| <input type="checkbox"/>         | Dialectical Behavioral Therapy          | <input type="checkbox"/> | Autism Spectrum                       |
| <input type="checkbox"/>         | EMDR                                    | <input type="checkbox"/> | Disruptive Behavior Disorders         |
| <input type="checkbox"/>         | Family Systems                          | <input type="checkbox"/> | Dissociative Disorders                |
| <input type="checkbox"/>         | Gestalt                                 | <input type="checkbox"/> | Eating Disorders                      |
| <input type="checkbox"/>         | Hypnosis                                | <input type="checkbox"/> | Impulse Disorders                     |
| <input type="checkbox"/>         | NLP                                     | <input type="checkbox"/> | Mood Disorders                        |
| <input type="checkbox"/>         | Outcomes Oriented Therapy               | <input type="checkbox"/> | Personality Disorders                 |
| <input type="checkbox"/>         | Play Therapy                            | <input type="checkbox"/> | Physical Abuse                        |
| <input type="checkbox"/>         | Psychoanalytic                          | <input type="checkbox"/> | PTSD                                  |
| <input type="checkbox"/>         | Rationale Emotive Therapy               | <input type="checkbox"/> | Schizophrenia                         |
| <input type="checkbox"/>         | Solution Focused Therapy                | <input type="checkbox"/> | Sexual Abuse (Adults)                 |
| <input type="checkbox"/>         | Tobacco Cessation                       | <input type="checkbox"/> | Sexual Abuse (Children)               |
| <input type="checkbox"/>         | Trauma Focused – CBT                    | <input type="checkbox"/> | Sexual Disorders                      |
| <input type="checkbox"/>         | Other (please specify)                  | <input type="checkbox"/> | Substance Abuse/ Dependence Disorders |
| <input type="checkbox"/>         | Methadone/ Suboxone Medication Services | <input type="checkbox"/> | Other (please specify)                |
| <input type="checkbox"/>         |   | <input type="checkbox"/> |                                       |

**Credentialing Information**

Are you registered with CAQH (Coalition for Affordable Quality Healthcare)?  Yes  No  
 In lieu of completing a State specific Credentialing Application, would you like Cenpatico’s credentialing department to use your CAQH information?\*  Yes  No

If “Yes,” what is your CAQH Provider ID number? \_\_\_\_\_  
*\*Please note that if you choose to use your CAQH materials, you must still provide Cenpatico with evidence of insurance, copies of license/ board certifications, DEA/ CDS certificate (if applicable) and a copy of your CV*  
*\*If you are NOT registered with CAQH, you must include a copy of your Credentialing Application*

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