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:** ______________________

Clinic Name: ____

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	

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

Identify the percentage of your practice dedicated to treating the following patient populations;
(Total must equal 100%)
Young Child (0-5 yrs.) _______% Child (6-11 yrs.)_______% Adolescent (12-17 yrs.) _______%
Adult (18-64 yrs.) _______% Geriatric (65+) _______%

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

☐ Nursing Home ☐ Hospital-Based ☐ Home-Based

☐ School-Based

Please select the behavioral health disorders and the treatment modalities you practice.
(Check those that apply)

	Disorders		Treatment Modalities
	Addictive Disorders		ABA (Applied Behavior Analysis)
	ADD/ ADHD		Evaluation/ Assessment
	Adult ADD		Relapse Prevention
	Adjustment		Group Therapy
	Anxiety		Individual Therapy
	Autism Spectrum Disorders		Family Therapy
	Chronic Pain/ Pain Management		Psychological Testing
	Depression		Neuropsychological Testing
	Developmentally Disabled		Crisis Management
	Cultural Issues		Biofeedback
	Domestic Violence		Hypnosis
	Eating Disorders		Stress Management
	Impulse Disorders		Medication
	Infertility		Couples Therapy
	Loss/ Bereavement		Chemical Dependency assessment
	Medical Illness/ Chronic Illness		Cognitive Therapy
	Mood Disorders		EMDR
	Parenting		ECT
	Personality Disorders		Critical Incident Debriefing
	Reactive Attachment Disorder		Brief Therapy
	Schizophrenia		Other (please specify)
	Separation/ Divorce		
	Sexual Dysfunction		
	Sexual/ Physical Abuse (Adults)		
	Sexual/ Physical Abuse (Children)		
	Stress Management		
	Tobacco Cessation		
	Trauma/ PTSD		
	Work Related Problems		
	Other (please specify)		

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:** _________________________