Behavioral Health Network Provider Application

THIS IS NOT A CREDENTIALING APPLICATION

Provider Type: **Application Date:**

☐ Individual/Solo Practitioner
☐ Group Member
☐ Group

SECTION I – Individual and/or Group Member Information

Last Name	First Name	Middle Initial	Degree	
Date of Birth	SSN #	Gender	License Type	License #
NPI # *(Individual)*	DEA #	CAQH ID #	CDS #	
EMAIL	EIN/TIN # *(Individual)* *(only if billing as individual)*		Office Phone #	

SECTION II – Group Information

Group Name (DBA)*Pay to this name? ☐	Group Legal Name *(if different)**Pay to this name? ☐
Group NPI #	Group EIN/TIN #
Is your group currently contracted with HMC HealthWorks?	Name of primary contact person/title
☐ YES ☐ NO	
Contact Phone:	Contact Email:

SECTION III – Practice Location and Correspondence

Primary Physical Practice Address (cannot be a P.O. Box)			Phone	Ext
City	State	Zip Code	Fax	
Is mailing address same as physical practice address? *(If no, please enter mailing address below)*			☐ Yes ☐ No	
Mailing Address			Attention	
City	State		Zip Code	
Is billing address same as physical practice address? Is billing address same as mailing address? *(If the answer is "NO" to both, please enter billing address)*			☐ Yes ☐ No ☐ Yes ☐ No	
Billing Address			Attention	
City	State		Zip Code	
Billing Contact Name/Title	Billing Contact Phone		Billing Contact Email	
If your physical practice location is different from your mailing address, do you want clinical correspondence, including authorization letters mailed to your physical practice location? ☐ YES ☐ NO – send to my mailing address				

SECTION III – Practice Information

General Categories	Age Categories
☐ Mental Health ☐ Substance Abuse ☐ Employee Assistance Program (EAP) ☐ Autism	☐ Younger Child (0-5) ☐ Older Child (6-12) ☐ Adolescent (13-17) ☐ Adult (18-64) ☐ Geriatrics (65+) ☐ All Ages

Languages Spoken Fluently (check all that apply)	Ethnicity (check all that apply)
☐ English ☐ Spanish ☐ French ☐ ASL (American Sign Language) ☐ Other: *(please write below)*	☐ Asian/Pacific Islander ☐ Black/African American ☐ Hispanic/Latino ☐ Native American/Alaskan ☐ White/Caucasian ☐ Other: *(please write below)*

Specialties (check all that apply)

☐ ADD/ADHD	☐ DIALECTIC BEHAVIORAL THERAPY-DBT	☐ NEUROPSYCH TESTING
☐ ADJUSTMENT TO ILLNESS/DISABILITY	☐ DISSOCIATIVE DISORDERS	☐ OBSESSIVE-COMPULSIVE-OCD
☐ ADOPTION	☐ DOMESTIC VIOLENCE	☐ OCCUPATIONAL ISSUES
☐ ANGER MANAGEMENT	☐ DUAL DIAGNOSIS	☐ OUTPATIENT DETOXIFICATION
☐ ANXIETY	☐ EATING DISORDERS	☐ PAIN MANAGEMENT
☐ APPLIED BEHAVIORAL ANALISIS-ABA	☐ EMDR	☐ PARENTING ISSUES
☐ AUTISM SPECTRUM DISORDER	☐ FAMILY THERAPY	☐ PERSONALITY DISORDERS
☐ BIOFEEDBACK	☐ GAMBLING	☐ PHARMACOLOGY-MED MGMT
☐ BIPOLAR	☐ GAY-LESBIAN	☐ PLAY THERAPY
☐ CERTIFIED EAP	☐ GENDER IDENTITY	☐ POST TRAUMATIC STRESS-PTSD
☐ CHEMICAL DEPENDENCY	☐ GERIATRIC PSYCHIATRY	☐ PSYCHOLOGICAL TESTING
☐ CHILD ABUSE	☐ GRIEF COUNSELING	☐ PSYCHOTIC DISORDERS
☐ CHRISTIAN COUNSELING	☐ GROUP THERAPY	☐ SAP
☐ CHRONIC PAIN	☐ HEARING IMPAIRED	☐ SELF MUTILATION
☐ CISD	☐ HIV/AIDS	☐ SEXUAL ADDICTION
☐ CODEPENDENCY	☐ HYPNOTHERAPY	☐ SEXUAL DYSFUNCTION
☐ COGNITIVE BEHAVIORAL THERAPY-CBT	☐ IN HOME THERAPY	☐ SEXUAL-PHYSICAL ABUSE
☐ COMORBIDITY	☐ LEARNING DISABILITIES	☐ STRESS MANAGEMENT
☐ COUPLES COUNSELING	☐ LIFE MANAGEMENT COUNSELING	☐ TERMINAL ILLNESS
☐ CRISIS INTERVENTION	☐ MANAGED DISABILITY	☐ TRAUMATIC BRAIN INJURY-TBI
☐ CULTURAL DIVERSITY	☐ MEN'S ISSUES	☐ WOMEN'S ISSUES
☐ DEPRESSION	☐ MOOD DISORDERS	

List any culturally diverse specialties:

Hours of Availability

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

Additional Practice Locations				
Location 2 Address (cannot be a P.O. Box)			Phone	Ext
City	State	Zip Code	Fax	
Location 3 Address (cannot be a P.O. Box)			Phone	Ext
City	State	Zip Code	Fax	
Are the mailing and billing addresses for this (these) additional location(s) the same as those listed for the primary location? *(If no, please provide the mailing/billing addresses for your additional practice locations on a separate sheet of paper and attach to this application)*			☐ YES ☐ NO	

HMC HealthWorks Contracting Checklist:

☐ Completed Behavioral Health Provider Application

☐ Executed Provider Agreement (Contract)

☐ Copy of Provider's Clinical License

☐ Copy of Provider or Group W9

☐ Executed Fee Schedule

☐ Sample CMS 1500 Form (only if provider bills paper claims)

Please return contracting documents via Mail, Fax or Email to:

HMC HealthWorks
Attn: Provider Relations Department
5840 Banneker Rd, Suite 270
Columbia, MD 21044
providerrelations@hmcebs.com
Fax: 860-785-4860
Phone: 855-487-8914

HMC HealthWorks contracts with the following provider types:

MD/DO-Psychiatrists, Certified Addictionologists
PMHNP-Psychiatric Mental Health Nurse Practitioners
PhD/PsyD- Psychologists, Neuropsychologists
Masters Level Therapists – LPC, LCPC, LPCC, LCSW, LMFT, MFCC *(must be independently licensed)*
ABA Groups; BCBAs, ABA Para-professionals
Non-Covered Provider Types: LISAC, LISW, SAC, ASW, RN, MFT-I (Interns), Students