

Optima Behavioral Health Provider Credentialing Packet

Thank you for your interest in becoming a participating provider in the Optima Behavioral Health (OBH) Network. We are currently accepting applications from behavioral health providers licensed for independent practice and board certified MDs. Please review the following instructions to ensure acceptance of your application.

1. **Please visit WWW.CAQH.ORG to complete your application.** OBH only accepts the CAQH (Council for Affordable Quality Healthcare) application. (If you do not have a CAQH provider ID, please download and complete the CAQH ID request form on the “Providers” page of www.optimabehavioralhealth.com.)
2. **Complete the “OBH Application Checklist for CAQH”.** *OBH will not accept or process an incomplete application. Omission of any information or supporting documentation will result in your application being returned to your office for correction. OBH adheres to the highest NCQA standards; there are no exceptions to the credentialing process.*

3. **Once your CAQH application is complete (with your resume/Curriculum Vitae attached), please complete and return this packet, which includes the following:**

- **OBH Application Checklist** – please confirm your application contains all required information.
 - **Behavioral Health Provider Information** – please list all locations at which you will perform services
 - **Member Matching Information** – this information is used during the referral process to match members with you as a provider once you have been credentialed
 - **Optima Health Authorization and Release** – please read, sign, and date this document (*Please note – your application must be received within 60 days of your signature.*)
 - **Cross Coverage** – this form is only necessary if you have not listed any partners/associates on CAQH
- Please fax to Network Management: 757-552-7114 (Hampton Roads and Greater Richmond)
540-890-3468 (Areas north and west of Richmond)**

The credentialing process will begin once this packet is received and the application is deemed complete.

4. **When we receive your credentialing packet, we will send a contract for your review and signature. Please return as soon as possible.** OBH cannot move forward with the review of your application until your signed contract is received. (If you are part of a practice that has a group contract in place with OBH, you will not receive a contract. Please check with your practice owner/manager for this information.)

The credentialing process usually takes between 60-90 days upon receipt of a complete and correct application. Upon approval by the OBH Credentialing Committee, you will receive a letter of approval, followed by a welcome letter with your Optima provider number. **Once you have received a welcome letter, you may then begin to provide services to OBH covered members.**

If you have any questions about the requested information or about the credentialing process, please contact Provider Services at 757- 552-7174 or 800-648-8420. Thank you - we look forward to working with you.

Sincerely,
Optima Behavioral Health
Network Management

Enclosures

OBH APPLICATION CHECKLIST FOR CAQH

Please complete this checklist to confirm the following information is included on your CAQH application. This checklist must be returned to OBH. Thank you.

Personal Information and Professional IDs

_____ All state license(s) information

_____ NPI number

Practice Location Information

_____ All practices and locations at which you will be providing services to OBH members

_____ Partners and Associates or Covering Colleagues

-List any participating OBH partners/associates within your practice or a colleague outside of your practice who will cover for you in the event of your absence.

Professional Liability Insurance Carrier

_____ Liability insurance limits are at least equal to the VA state cap requirements – \$2 million per occurrence/ \$4 million aggregate.

_____ Two (2) years of liability history listed under “additional liability coverage” - Seven (7) years for MDs (This information is required whether covered as an individual or under a group policy).

_____ Any gaps in liability history are explained – notated in CAQH

Work History and References

_____ Ten years of work history

_____ Gaps in work history greater than 6 months are explained – notated in CAQH

Disclosure Questions

_____ Explanation for any “yes” answers to disclosure questions

Attachments : the following documents are required to be attached to the CAQH application.

(For assistance with attaching documents, contact the CAQH provider help desk: 1-888-599-1771.)

_____ Current Resume or CV in month year format - this is not requested by CAQH, however, it is required for Optima

_____ Completed W-9 for all practices - this is not requested by CAQH, however, it is required for Optima

_____ Current State License(s)

_____ Current Certificate(s) of Insurance – including any group policies

_____ Cross Coverage Form – required if covering colleague is outside of practice location

_____ Board Certificate (if applicable)

_____ DEA Registration Certificate (if applicable)

_____ ECFMG (if applicable)

BEHAVIORAL HEALTH PROVIDER INFORMATION

(all fields-including Taxonomy- are required)

Provider Name _____ License Type _____
License # _____ DEA# (if applicable) _____ Degree _____
Individual NPI # _____ Taxonomy # _____
SSN # _____ DOB _____
CAQH # _____ Provider Email _____

Are you a Medicaid Provider? Yes No If yes, MCD# _____

Are you a Medicare provider? Yes No If yes, MCR# _____

PRIMARY PRACTICE INFORMATION

Practice Name _____ Tax Id # _____
Practice NPI # _____ Practice Email _____
Practice Address _____

Phone _____ Fax _____ Is this a confidential fax line? Yes No

Office Hours

Monday _____ Tuesday _____ Wednesday _____ Thursday _____
Friday _____ Saturday _____ Sunday _____

ADDITIONAL OFFICE LOCATION / PRACTICE INFORMATION

Additional Office Location Additional Practice

Practice Name _____ Tax Id # _____
Practice NPI # _____ Practice Email _____
Practice Address _____

Phone _____ Fax _____ Is this a confidential fax line? Yes No

Office Hours

Monday _____ Tuesday _____ Wednesday _____ Thursday _____
Friday _____ Saturday _____ Sunday _____

Additional Office Location Additional Practice

Practice Name _____ Tax Id # _____
Practice NPI # _____ Practice Email _____
Practice Address _____

Phone _____ Fax _____ Is this a confidential fax line? Yes No

Office Hours

Monday _____ Tuesday _____ Wednesday _____ Thursday _____
Friday _____ Saturday _____ Sunday _____

MEMBER MATCHING INFORMATION

Optima Behavioral Health uses this information to refer our members to providers who meet their specific needs.
To maximize your referrals, it is important to check each category that applies.

Provider Name: _____ **NPI** _____ **Tax ID** _____

1. Office Hours

Monday _____ Tuesday _____ Wednesday _____ Thursday _____
 Friday _____ Saturday _____ Sunday _____

2. Office Accessibility

- Wheelchair Accessible Use of TDD Public Transportation within one block

3. Populations Seen

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> Younger Children (0-5 years) | <input type="checkbox"/> Women | <input type="checkbox"/> Gay / Lesbian | <input type="checkbox"/> Philippine |
| <input type="checkbox"/> Older Children (6-12 years) | <input type="checkbox"/> Family | <input type="checkbox"/> In-Patient | <input type="checkbox"/> Child/Adolescent |
| <input type="checkbox"/> Adolescents (13-18 years) | <input type="checkbox"/> Couples | <input type="checkbox"/> Korean | Training/Fellowship |
| <input type="checkbox"/> Adults | <input type="checkbox"/> Geriatric | <input type="checkbox"/> Hispanic | <input type="checkbox"/> Child/Adolescent |
| <input type="checkbox"/> Men | <input type="checkbox"/> Step Families | <input type="checkbox"/> Vietnamese | Board Certified MD |

4. Treatment Categories (please check all that apply)

- | | | |
|--|---|--|
| <input type="checkbox"/> Psychotherapy - Couple | <input type="checkbox"/> Development Disability | <input type="checkbox"/> Job Stress |
| <input type="checkbox"/> Psychotherapy - Family | <input type="checkbox"/> EAP Services | <input type="checkbox"/> Mood Disorder |
| <input type="checkbox"/> Psychotherapy - Group | <input type="checkbox"/> EAP CISM Trained | <input type="checkbox"/> Neuropsychological Assessment |
| <input type="checkbox"/> Psychotherapy - Individual | <input type="checkbox"/> EAP SAP Trained | <input type="checkbox"/> Organic Brain |
| <input type="checkbox"/> Addictions | <input type="checkbox"/> Eating Disorders | <input type="checkbox"/> Outpatient Traditional Practice for Mental Health |
| <input type="checkbox"/> ADHD | <input type="checkbox"/> ECT-Inpatient | <input type="checkbox"/> Parenting |
| <input type="checkbox"/> Anger Management | <input type="checkbox"/> ECT-Outpatient | <input type="checkbox"/> Pharmacotherapy |
| <input type="checkbox"/> Anxiety Disorder | <input type="checkbox"/> Evaluation & Referral: Mental Health | <input type="checkbox"/> Phobias/Habit Disorders |
| <input type="checkbox"/> Behavior Modification | <input type="checkbox"/> Evaluation & Referral: Substance Abuse | <input type="checkbox"/> Physically Impaired |
| <input type="checkbox"/> Biofeedback | <input type="checkbox"/> Family System | <input type="checkbox"/> Psychoanalytic/Psychodynamic |
| <input type="checkbox"/> Blind/Visually Impaired | <input type="checkbox"/> Family/Victim Violence | <input type="checkbox"/> Psychological Testing |
| <input type="checkbox"/> Brief Treatment: Mental Health | <input type="checkbox"/> Forensic Evaluation | <input type="checkbox"/> Psychosomatic/Somatoform |
| <input type="checkbox"/> Brief Treatment: Substance Abuse | <input type="checkbox"/> Grief | <input type="checkbox"/> Psychotic Disorder |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Head Injury Patients | <input type="checkbox"/> PTSD |
| <input type="checkbox"/> Child/Adolescent | <input type="checkbox"/> Hearing Impaired | <input type="checkbox"/> Separation/Divorce |
| <input type="checkbox"/> Christian Focus | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Sexual Disorders |
| <input type="checkbox"/> Chronic Pain | <input type="checkbox"/> Hypnosis | <input type="checkbox"/> Sexual/Physical Abuse |
| <input type="checkbox"/> Cognitive-Behavioral | <input type="checkbox"/> Inpatient Psychiatry | <input type="checkbox"/> Substance Abuse |
| <input type="checkbox"/> Crisis Intervention | <input type="checkbox"/> Intellectually Disabled | <input type="checkbox"/> Terminally I |
| <input type="checkbox"/> Depression | | |

5. Foreign Languages

Language _____ Language _____ Language _____

Optional Provider Information *(It is our experience that patients often express preferences for providers of a particular ethnic background or gender, and employers may wish to determine if our network reflects the ethnic/gender profile of their employees. If you wish to volunteer to provide the following information, it will be held in strictest confidence and will be used only when a patient indicates such information is important in selecting a provider. This information will not be released to any other party, except in aggregate form.)*

Gender

- Male
 Female

Ethnic Background

- ____ African-American
 ____ American Indian/Alaska Native
 ____ Asian

____Caucasian

- ____Hispanic
 ____Multi-Racial
 ____Other _____

Authorization and Release

A. General Conditions of Application

In return for my application being considered and processed, I agree to be legally bound by the following terms and conditions:

1. I know that it is my responsibility to produce adequate information so that my application can be properly evaluated. In addition to the information provided in this application, I will provide Sentara Health Plans, Inc. (hereinafter referred to as "the applicable Sentara Affiliated Health Plan(s)") with any additional information that they or their respective representatives may request. Failure to provide any requested information will cause my application to be incomplete, so that it cannot be processed.
2. I will keep this application current by informing the Sentara Affiliated Health Plan(s) through the Optima Health Medical Director, of any changes in the information provided.
3. I will be available for interviews with regard to this application.
4. As applicable and appropriate, I will accept committee assignments and other reasonable duties and responsibilities assigned to me.
5. I will provide timely and continuous care for all my patients.
6. My participation with the applicable Sentara Affiliated Health Plans is dependent upon my continued demonstration of professional competence and cooperation and acceptable performance of all related responsibilities.
7. I have had an opportunity to read a copy of the contract of the applicable Sentara Affiliated Health Plan(s), and I specifically agree to abide by the policies, rules and regulations, and directives that are in force during the time I am appointed.
8. I will abide by the applicable Sentara Affiliated Health Plan(s)' Corporate Compliance Policy and any laws, regulations and standards of conduct applicable to my profession, participation in any federal health program, or activities at the applicable Sentara Affiliated Health Plan(s) and will report any known or suspected violation to the Optima Health Medical Director.
9. All information provided in or attached to this application is accurate and complete. I know that any misrepresentation, misstatement or omission from this application shall constitute cause to stop the processing of my application. If my misrepresentation, misstatement, or omission is discovered after I have been appointed, that discovery may be an automatic relinquishment of my appointment and clinical privileges. Neither situation entitles me to any of the hearing or appeal rights contained in the policies at the applicable Sentara Affiliated Health Plan(s).

B. Information Sharing, Release, and Immunity

1. I understand that the entities to which I am applying for provider status is affiliated with Sentara Healthcare. I also understand that my Confidential Peer Review Information includes information and/or documentation regarding my clinical competence and/or professional conduct that is obtained or produced as part of the credentialing, quality assessment, and/or peer review processes conducted by Sentara Health Plans, Inc., and/or the Sentara Affiliated Health Plan(s). Such sharing is solely for the purposes of credentialing and peer review.
2. The Sentara Affiliated Health Plan(s) at which I am granted, or seek, participation, and Sentara Health Plans, Inc. may release to one another, and to the Sentara Healthcare Medical Affairs Committee, Confidential Peer Review Information regarding my practice.
3. Confidential Peer Review Information that is released shall be used solely for credentialing and peer review purposes and all Confidential Peer Review Information will be handled in confidence, in accordance with the protections and privileges afforded to peer review information under state and/or federal law.
4. I accept the following conditions and intend to be legally bound by them:
 - (a) To the fullest extent permitted by law, I extend immunity to, release from any and all liability, and agree not to sue Sentara Healthcare, the Sentara Healthcare Medical Affairs Committee, Sentara Health Plans Inc., the Sentara Affiliated Health Plan(s) at which I am granted, or seek, participation, their respective representatives, or any third parties for any matter relating to appointment, reappointment and clinical privileges, and participation in the Sentara Affiliated Health Plan(s), or my qualifications for the same.
 - (b) I authorize Sentara Health Plans Inc., and the Sentara Affiliated Health Plan(s) at which I am granted, or seek, participation and their respective representatives to consult with any third party who may have information bearing on my professional qualifications, credentials, clinical competence, character, ability to perform safely and competently, ethics, behavior, or any other matter reasonably having a bearing on my qualifications for participation in the Sentara Affiliated Health Plan(s). This authorization includes the right to inspect or obtain communications, reports, records, recommendations or disclosures that may be relevant to such questions. I specifically authorize these third parties to release the information to Sentara Health Plans Inc., and the Sentara Affiliated Health Plan(s) at which I am granted, or seek, participation and their respective representatives upon request.
 - (c) I also authorize Sentara Health Plans Inc., and the Sentara Affiliated Health Plan(s) at which I am granted, or seek, participation and their respective representatives to release such information to other hospitals, health care facilities and managed care entities and

their agents, who seek such information for the purpose of evaluating my qualifications pursuant to a request for appointment and clinical privileges and participating provider status or other credentialing matter.

- (d) I agree that the hearing and appeal procedures set forth in the Sentara Affiliated Health Plan(s)' policies are my sole and exclusive remedy with respect to any professional review action taken at the Sentara Affiliated Health Plan(s).

- (5) In the event that the terms and conditions of this release conflict with the terms and conditions of the Coalition for Affordable Healthcare's (CAQH) release, the terms and conditions of this release shall control as they relate to Sentara Healthcare.

Signature of Practitioner

Printed or Typed Name of Practitioner

Date

Optima Behavioral Health
Cross Coverage Form

Name of Covering Optima Provider

Practice Name of Covering Optima Provider

Phone number where Covering Provider may be easily reached

This is to confirm that I, _____
Name of Covering Optima Provider

will cover any members in crisis for _____
Name of Provider in Credentialing Process

in the event of her/his unavailability.

Signature of Covering Optima Provider

Date

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- Please have a covering colleague **who participates with Optima Behavioral Health** complete this form in its entirety.
 - Submit this form only if you have NOT listed any **participating** partners/associates on your CAQH application.
 - Please note that all partners, associates and/or covering colleagues should also be listed in your CAQH application.