

Dear Provider,

Thank you for your interest in becoming a participating provider in the Optima Behavioral Health (OBH) Network. Please review the following instructions to ensure acceptance of your application.

OBH accepts online applications from the Council for Affordable Quality Healthcare (CAQH) universal database. (If you have not completed a CAQH application, you may contact OBH Network Management at 757-552-7174 or toll free at 800-648-8420 to obtain a CAQH ID and initiate the application process.)

Please carefully review your CAQH application for completion. (See pg. 2 “OBH Application Requirements.”)
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 so that the necessary changes can be made. OBH adheres to the highest NCQA standards; there are no exceptions to the credentialing process.

Once your CAQH application is complete with all supporting documentation attached (**including your resume/Curriculum Vitae**), complete and sign the following documents:

- **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.*)

**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 these forms are received by OBH.

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. If you are with a contracted group, once you are set up in the OBH system, you will receive a welcome letter with your Optima provider number. If you are not with a contracted group, you will receive two contracts for your signature. Upon receipt of your signed contracts, a fully executed copy will be returned for your files, along a welcome letter with your Optima Provider number. **Once you have received a welcome letter, you may then begin to provide services to and receive referrals for 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 toll-free 800-648-8420. Thank you - we look forward to working with you.

Sincerely,
Optima Behavioral Health
Network Management

Enclosures

OBH APPLICATION REQUIREMENTS

The following is a summary the CAQH application. Each section on the application must be completed by all applicants. *The items in bold indicate commonly omitted information – please review your application for these items to avoid application rejection.* Thank you.

- (Sect. 1) Personal Information and Professional IDs
 - **Include all state license(s) information**
 - **Include NPI provider number** (*OBH cannot accept an application without an NPI #*)
- (Sect. 2) Education and Training – please provide all applicable information
- (Sect. 3) Professional/Medical Specialty Information
 - Include primary specialty and any applicable secondary specialties
- (Sect. 4) Practice Location Information
 - Include all practices and locations at which you will be providing services to OBH members
 - **Complete either “Partners and Associates” or “Covering Colleagues” information – Please provide information regarding the participating OBH Provider who will cover for you in the event of your absence. If you complete the “Covering Colleagues” information, you must return a signed and dated “OBH Cross Coverage Form” for all covering colleagues. (This form is enclosed with this packet.)**
- (Sect. 5) Hospital Affiliations – please provide all applicable information
- (Sect. 6) Professional Liability Insurance Carrier
 - **Malpractice limits must meet the VA state cap requirements, currently \$2 million per occurrence/ \$4 million aggregate.**
 - **Insurance coverage for the previous two (2) years must be listed in CAQH (whether covered by an individual or under a group policy). If there is any gap in malpractice history, you must provide an explanation in this section of CAQH.**
- (Sect. 7) Work History and References
 - **Ten years of work history is required. If there is any gap in work history during this time frame, you must complete “Gaps in Professional/Work History” on CAQH. (Any gap between education and employment for longer than 6 mos. must also be explained.)**
- (Sect. 8) Disclosure Questions
 - If you answer “yes” to any of these questions, you must provide a full explanation on the “Supplemental Disclosure Question Explanation Form” on CAQH. *You may fax any additional information/documentation to support your explanation, if needed.*
- Attachments

Please ensure the following required documents are attached to your CAQH application. (For assistance, contact the CAQH provider help desk: 1-888-599-1771.)

 - **Current Resume or Curriculum Vitae – this information is not requested by CAQH, but it is a requirement for Optima Behavioral Health.**
 - **Current State License(s)**
 - **Current Certificate of Insurance** – if this document will expire during the credentialing process (60-90 days after submission), you must send an updated certificate prior to the expiration date. If this is not received, we will be unable to proceed with your application.
 - **DEA Registration Certificate** (if applicable)
 - **Board Certificate** (if applicable)
 - **ECFMG** (if applicable)

BEHAVIORAL HEALTH PROVIDER INFORMATION

(all fields are required)

Provider Name _____

License Type _____ License # _____ DEA# (if applicable) _____

SSN # _____ DOB _____

Individual NPI # _____ Taxonomy # _____

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(Group) NPI # _____

Practice Address _____

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

Practice Office Hours

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

ADDITIONAL OFFICE LOCATION / PRACTICE INFORMATION

Additional Office Location Additional Practice

Practice Name _____ Tax Id # _____

Practice(Group) NPI # _____

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(Group) NPI # _____

Practice Address _____

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

Office Hours

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

5. Foreign Languages

Language _____ Language _____ Language _____

Optional 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 ____ Caucasian ____ Other
 ____ American Indian/Alaska Native ____ Hispanic
 ____ Asian ____ Multi Racial

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*

This is to confirm that I, _____
(Name of covering practitioner)
will cover any members in crisis for _____
(Name of credentialing practitioner)
in the event of his/her unavailability. If there are any questions, I may be
reached at phone # _____.

Print Name of covering practitioner

Signature of covering practitioner

Date

***THIS FORM IS ONLY REQUIRED IF NO "PARTNERS OR ASSOCIATES" ARE LISTED ON THE CAQH APPLICATION.**