TUFTS Health Plan

ANCILLARY PRACTITIONER DATA FORM
BEHAVIORAL HEALTH CLINICIAN/
LICENSED ALCOHOL AND DRUG COUNSELOR 1

Please email to AHCBehavioralHealth@tufts-health.com or fax to **617.673.0909**.
Please note: A credentialing application must also be submitted at proview.caqh.org.

GENERAL INFORMATION – MISSING INFORMATION WILL DELAY YOUR APPLICATION

Name _____
Last First Middle Degree/Specialty

Individual NPI _____ Date of birth_____/_____/_____ SS# _____-_____-_____

Provider's email _____

DBA, Group or Practice Name (if applicable) _____

Are we adding you to a group practice? YES ☐ NO ☐ Are you a Medicare participating provider? YES ☐ NO ☐

CAQH Information
Is your CAQH application updated and reattested to within the last 3 months? YES ☐ NO ☐
Did you include 5-year work history in CAQH in month/year format? YES ☐ NO ☐
CAQH ID# _____ Have you granted Tufts Health Plan access to your CAQH account? YES ☐ NO ☐

Payment Information Payee NPI _____ Tax ID# _____-_____

To whom should checks be made payable? _____

Payment Address (should match W-9 & CAQH) Payment Address Phone _____ Fax _____

Street _____ City, State ZIP _____

Mailing Address Mailing Address Phone _____ Fax _____

Street _____ City, State ZIP _____

Practice Address

Street _____ Phone _____

City, State ZIP _____ Fax _____

Service Hours: Mon_____Tue_____Wed_____Thu_____Fri_____Sat_____Sun_____

_____ Handicap Access? Yes ☐ No ☐ Are translation services available? Yes ☐ No ☐
Languages other than English at this location

For additional addresses check here ☐ and attach a separate sheet. Please include all practice addresses for directories and update all addresses with www.CAQH.org.

Whom may we contact if we have any questions?

Name _____ Phone _____ Fax _____

Email _____

TYPE OF PRACTITIONER – Check all that apply

☐ Psychologist: ☐ Ph.D. ☐ Ed.D. ☐ Sc.D. ☐ Psy.D. ☐ D.Min
☐ Licensed Marriage and Family Therapist
☐ Psychiatric and Behavioral Health Nurse Practitioner: ☐ Prescribing ☐ Non-Prescribing ☐ LADC1
☐ Psychiatric Clinical Nurse Specialist: ☐ Prescribing ☐ Non-Prescribing ☐ MLADC
☐ Licensed Independent Clinical Social Worker
☐ Licensed Behavioral Health Counselor

State of Rhode Island Psychologists only:
Do you provide Applied Behavior Analysis services? ☐ Yes ☐ No

☐ Other: _____

REQUIRED CREDENTIALING/CONTRACTING DOCUMENTS – Please attach/complete

☐ Documentation of current professional liability insurance ($1 million per incident/$3 million aggregate). Must show the individual provider's name on the certificate, roster or a letter from the insurance company unless the professional liability information in CAQH is current and attested to. ***(required)***

☐ Completed Past 5 Years' Work History Form (enclosed) ***(required)***

☐ Form W-9 for payments (payment address should match CAQH and above) ***(required)***

☐ Copy of board certification (LICSW and prescribing nurses only) ***(if applicable)***
Please note: *this is **not** your state license nor is it membership alone in an association such as the NASW. Board certification is an additional, voluntary certification process whereby a person is tested and approved to practice in a specialty field after successful completion of the requirements of a board of specialists in that field (for example, The American Nurses Credentialing Center or The National Association of Social Workers).*

☐ Psychiatrist or prescribing nurse to whom you refer for medication management ***(required)***

Provider's name _____

☐ Provider who provides your emergency and vacation coverage ***(required)***

Provider's name _____

Internal Use:

PROV ID _____
PCAT 01 05, TOP 12 49 50 55 65 66, PRAC 01 02 05, GROUP/PAYEE _____
SPEC 1200 1500 6000 6200 6300 6800 6900 7000 7100 9900
(Revised 05/16, #5166777) PI Initials _____ Date_____ PO Initials _____ Date _____ REST EX 77