TUFTS Health Plan

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

Please email Tufts_Health_Plan_Credentialing_Department@tufts-health.com or fax to **617.972.9591**.
Please note: A credentialing application must also be submitted at proview.caqh.org.

GENERAL INFORMATION – MISSING INFORMATION WILL DELAY YOUR APPLICATION

Please select applicable Plans for which you would like to be credentialed:

☐ Tufts Health Plan Commercial/Tufts Health Freedom Plan ☐ Tufts Health Public Plans- Massachusetts

☐ Tufts Health RITogether ☐ Tufts Health Medicare Preferred HMO ☐ Tufts Health Plan Senior Care Options (SCO)

Name _____
Last First Middle Degree/Specialty

Individual NPI _____ Date of birth____/____/_____ SS# _____-_____-_____

PID/SIL if applicable _____ 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 ☐

Are you a Medicaid/MassHealth participating provider? YES ☐ NO ☐

Participating in Rhode Island Medical Assistance Program? 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
☐ Psychiatric Clinical Nurse Specialist: ☐ Prescribing ☐ Non-Prescribing
State of Rhode Island Psychologists only:
Do you provide Applied Behavior Analysis services? ☐ Yes ☐ No

☐ Licensed Independent Clinical Social Worker
☐ Licensed Behavioral Health Counselor
☐ LADC1
☐ MLADC
☐ BCBA/LABA
☐ Other: _____

Race *Please check all that apply.*

☐ American Indian/Alaska Native
☐ Asian
☐ Black/African-American
☐ Native Hawaiian or other Pacific Islander
☐ White
☐ Other race
☐ Don't know
☐ Choose not to answer

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

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Special populations served *Please check all that apply.*

Patients diagnosed with:

- ☐ Chronic illness
- ☐ Co-occurring disorder
- ☐ Dual diagnosis (behavioral health and substance abuse)
- ☐ Eating disorders
- ☐ Firesetting
- ☐ HIV/AIDS
- ☐ Phobic disorders
- ☐ Post-traumatic stress disorder (PTSD)
- ☐ Serious and persistent behavioral illness
- ☐ Sexual abuse
- ☐ Trauma

Patients who are:

- ☐ Blind or visually impaired
- ☐ Children or adolescents
- ☐ Children in the custody of the DCF
- ☐ Deaf or hard of hearing
- ☐ Homeless
- ☐ People with disabilities
- ☐ Pregnant
- ☐ Sexual offenders

Patients receiving the following services:

- ☐ Cognitive behavioral therapy (CBT)
- ☐ Inpatient electroconvulsive therapy (ECT) services

☐ Other Please specify:_____

Ethnicity *Please check all that apply.*

- ☐ African
- ☐ African-American
- ☐ American
- ☐ Asian
- ☐ Asian Indian
- ☐ Brazilian
- ☐ Cambodian
- ☐ Cape Verdean
- ☐ Caribbean Islander
- ☐ Central American (not otherwise specified)
- ☐ Chinese
- ☐ Colombian
- ☐ Cuban
- ☐ Dominican
- ☐ Eastern European
- ☐ European
- ☐ Filipino
- ☐ Guatemalan
- ☐ Haitian
- ☐ Honduran
- ☐ Japanese
- ☐ Korean
- ☐ Laotian
- ☐ Mexican/ Mexican-American
- ☐ Middle Eastern
- ☐ Portuguese
- ☐ Puerto Rican
- ☐ Russian
- ☐ Salvadoran
- ☐ South American (not otherwise specified)
- ☐ Vietnamese
- ☐ Other ethnicity *Please specify:* _____
- ☐ Don't know
- ☐ Choose not to answer

Is the provider Hispanic, Latino, or Spanish? YES ☐ NO ☐ Choose not to answer ☐

Areas of Focus *Please check all that apply.*

- ☐ Attention-deficit/hyperactivity disorder (ADHD)
- ☐ Anger issues
- ☐ Anxiety
- ☐ Autism spectrum disorders
- ☐ Bipolar disorder
- ☐ Dialectical behavioral therapy (DBT)
- ☐ Depression
- ☐ Gay, lesbian, bisexual, transgender (LGBT) issues
- ☐ Gender identity disorder
- ☐ Geriatric behavioral health
- ☐ Group therapy
- ☐ Marriage and family therapy
- ☐ Medical illness and therapy
- ☐ Medication management and therapy
- ☐ Neuropsychological testing (adolescents)
- ☐ Neuropsychological testing (children)
- ☐ Obsessive-compulsive disorder (OCD)
- ☐ Postpartum depression and/or psychosis
- ☐ Play therapy
- ☐ Psychological testing (adolescents)
- ☐ Psychological testing (children)
- ☐ Sleep disorders
- ☐ Substance use

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Americans with Disabilities Act compliance *Please check all that apply.*

- ☐ Staff receives ADA-compliance training
- ☐ Practice can accommodate people who are physically disabled (e.g. accessible parking, wheelchair access to building)
- ☐ Practice allows wheelchair access to exam rooms
- ☐ Practice can accommodate people who are intellectually/cognitively disabled (e.g. on-site staff to explain instructions)
- ☐ Practice can accommodate people who are blind/visually impaired (e.g. service animals allowed, Braille directions available)
- ☐ Practice can accommodate people who are deaf/hard of hearing (e.g. American Sign Language or written instruction available)
- ☐ Practice is accessible by public transportation (e.g. bus, subway or commuter rail)

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

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