CarePartners of Connecticut

BCBA PRACTITIONER APPLICATION

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 Graduate Degree (List Type of Degree)

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

Provider's email _____ Sex: Female ☐ Male ☐

Discipline: ☐ Psychologist ☐ Social Worker ☐ Marriage & Family Therapist ☐ Mental Health Counselor ☐ BCBA ☐ BCABA (only for RI)

☐ Prescribing Psychiatric Nurse ☐ Non-Prescribing Psychiatric Nurse ☐ Other: (Specify) _____

DBA, Group or Practice Name (if applicable) _____

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

CAQH Information

CAQH ID# _____

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 ☐

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 _____

Primary Practice Address (general liability insurance must be attached for all practice locations) *# Years at this Site:* _____

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.proview.caqh.org.

Whom may we contact if we have any questions?

Name _____ Phone _____ Fax _____

Email _____

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)***
- ☐ State license
- ☐ Completed Past 5 Years' Work History Form ***(required)***
- ☐ Form W-9 for payments (payment address should match CAQH and above) ***(required)***
- ☐ Completed Practitioner Attestation Practice Site Standards Form ***(required)***
- ☐ One reference letter ***(required)***

Internal Use:

PROV ID _____ PCAT 01 05, TOP 94, PRAC 01 02 05, GROUP/PAYEE _____ SPEC 7100

(Revised 10/2018, #5169735) PI Initials _____ Date_____ PO Initials _____ Date _____ REST EX 77