CarePartners of Connecticut

ANCILLARY PRACTITIONER DATA FORM:
BEHAVIORAL HEALTH/SUBSTANCE USE DISORDER/METHADONE CLINIC

Please email to Provider_Information_Dept@point32health.org or fax to **617.972.9591**.

Please review Behavioral Health/Substance Use Disorder Clinic Application Procedures for a list of required attachments.

GENERAL INFORMATION

Contract/Legal Entity Name _____

DBA/Practice Name (if applicable) _____

Type of Clinic: ☐ Behavioral Health ☐ Substance Use Disorder/Methadone

NPI _____ Is the clinic Medicare participating? YES ☐ NO ☐

If yes, please enclose proof of Medicare participation (e.g., Medicare award letter)

Primary Practice Address

Street _____ Phone _____

City, State ZIP _____ Fax _____

Email _____

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

Secondary Practice Address

Street _____ Phone _____

City, State ZIP _____ Fax _____

Email _____

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.
Corporate affiliated providers with different names and locations need to complete separate applications.

Mailing Address Mailing Address Phone _____ Fax _____

Street _____ City, State ZIP _____

Corporate Affiliation (if different) _____

Street _____ City, State ZIP _____

Managed by _____

Please explain in detail any name changes that have occurred in the past 3 years and attach appropriate documentation:

_____

PRACTICE INFORMATION

President/CEO _____

Office Mgr/Contact Person _____ Phone _____ Fax _____

Email _____

Please provide the contact information for the person we should contact if we have any questions about the information on this form.

PAYMENT INFORMATION

Payee NPI _____ Tax ID# _____-_____

To whom should checks be made payable? _____

Payment Address Payment Address Phone _____ Fax _____

Street _____ City, State ZIP _____

Please enclose a copy of your W-9 form (request for taxpayer ID). Payee name and tax ID# must match information on your W-9.

Internal Use:

PROV ID _____

PCAT 01, TOP 24,45,67 PRAC 03 SPEC 9900

(#5165054/5183266) PI Initials _____ Date_____ PO Initials _____ Date _____ REST EX 77

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CERTIFICATION, AUTHORIZATION AND RELEASE

Contract/Legal Entity Name _____

DBA/Practice Name (if applicable) _____

In submitting this application for credentialing (or recredentialing) by CarePartners of Connecticut, Inc. or any CarePartners of Connecticut affiliate (as defined in your written agreement to provide services to CarePartners of Connecticut members) (collectively "Plan") I understand that it is the Provider's responsibility to produce the required information for the proper evaluation of its application and that failure to produce this information will prevent its application from being reviewed and acted upon. The undersigned hereby acknowledges that he or she is authorized and empowered to complete this application and enter into contracts on behalf of the Provider. By submission of this application for membership in the Plan Provider Network, the undersigned hereby:

1. Certifies under pains and penalties of perjury that the information contained herein, including all supporting materials, is true and complete to the best of his/her knowledge and belief. The Provider understands that its application will be reviewed based upon the information it has provided and other information obtained by Plan in accordance with its credentialing program. The Provider further understands that information which is found to be false could result in a denial or termination of Provider's network privileges.
2. Acknowledges and agrees that Plan or its agents may solicit information from past and former associates, health care organizations and any other relevant sources and review documents which Plan, in its discretion, deems relevant in assessing Provider's qualification for membership in the Plan provider network.
3. Authorizes the release of all such relevant information by any individual or organization and release from liability Plan and any such individuals or organizations which in good faith and without malice provide information bearing on the Provider's qualifications for the Plan provider network and/or credentialing status.
4. Authorizes the licensing agencies in any state in which the Provider is or has been licensed, to release information to Plan regarding any licensure information, any pending or final disciplinary action, and any other information relevant to the Provider's professional competence or status.
5. Agrees that all employed and/or contracted clinical staff and associates have been appropriately credentialed consistently with all applicable laws, requirements and standards.
6. Authorizes and requests Provider's professional liability insurance carrier to release information regarding any claim or action for damages pending or closed during the previous ten years, whether or not there has been a final disposition.
7. Agrees to notify Plan as soon as Provider becomes aware of any event which might reasonably affect Provider's Plan credentialing status, including the initiation of any disciplinary action by any certification or accreditation entity, any health care facility or regulatory agency.
8. Understands that it may not provide healthcare services to Plan members until it is credentialed and contracted by Plan.
9. Authorizes and releases from liability Plan for the good faith disclosure of credentialing information by Plan to the extent required by law, regulations, court order or other standards or requirements applicable to Plan.

_____ _____

Authorized Representative's Signature Date

_____

Authorized Representative's Name (Please Print)

_____

Authorized Representative's Title