Connecticut BHP
Supporting Health and Recovery

Dear Group Practice Provider:

Thank you for your participation with the Medicaid Network and The CT Behavioral Health Partnership (CT BHP). An important aspect of the responsibilities of the CT BHP is the management of the provider file, and we want to ensure that we have the most accurate information. Please note that these forms are ***separate from and in addition to*** the DXC Technology enrollment application. Any change in contracting or credentialing information should be directed to DXC at (800) 842-8440 with any new or updated information.

Your completion of the forms accompanying this letter will allow CT BHP to:

- Track clinical services that you provide, allowing you to obtain authorizations for reimbursement.
- Update you on any and all policy changes, and new developments.
- Ensure that our clinical and customer service teams make appropriate referrals.
- Allow you to indicate how and when you would like to be contacted.

Please complete the attached Provider Data Verification Form, including signatures and return within 10 days of receipt. Be sure to copy and complete page (3) for **each** practice location. Completed forms can be faxed to (855) 750-9862 or mailed to:

CT Behavioral Health Partnership
500 Enterprise Drive, Suite 4D
Rocky Hill, CT 06067
Attn: Provider Relations

Sincerely,

Provider Relations Department
Connecticut Behavioral Health Partnership

1. GROUP PRACTICE INFORMATION

(* indicates required fields)

A. PRIMARY DEMOGRAPHIC INFORMATION

Group Practice Name*			
DBA/Trade Name			
Primary Mailing Address		Primary Mailing Address Line 2*	
City*	County*	State*	Zip*
Telephone*: (include area code)		Fax*: (include area code)	
TIN/EIN Number: *	Medicaid Id Number:*	NPI Number:*	
E-mail Address:			

B. GROUP PRACTICE POINTS OF CONTACT

Managed Care Director	Phone ( ) Email
Person completing this application	Phone Email
Group Administrator	Phone ( ) Email

C. POPULATION TREATED

Identify the percentage of your practice dedicated to the following patient population categories (must total 100%):

Population	% of Practice	GENDER				Are You Currently Accepting New Patients?	
		M	F	Both			
Child (0-5) (YC)					⇒	☐ Yes	☐ No
Child (6-12) (CI)					⇒	☐ Yes	☐ No
Adolescent (13–17) (AO)					⇒	☐ Yes	☐ No
Adult (18-64) (AU)					⇒	☐ Yes	☐ No
Geriatric (65+) (GT)					⇒	☐ Yes	☐ No

Provider Signature (Required):_____ Date:_____

2. LOCATION INFORMATION

A. PROGRAM LOCATION

(Indicates required fields*)

Group Practice Name*				
Medicaid Number:*		NPI Number:*		
Practice Address Line 1 (street address required for referral purposes)		Practice Address Line 2		
City*	County*	State*	Zip*	Appointment Telephone* (include area code)
Contact Name (if applicable)		Fax Number* (include area code)		
Email*				

B. HOURS OF OPERATION (actual practice hours each day at <u>this</u> location. (**e.g., 8:00am to 4:30pm) Include** multiple practice hours **(e.g. 8:00 am to 12:00 pm. and 3 pm to 7 pm**):

Monday		Tuesday		Wednesday		Thursday		Friday		Saturday		Sunday	
From	To	From	To	From	To	From	To	From	To	From	To	From	To
From	To	From	To	From	To	From	To	From	To	From	To	From	To

Is this office handicapped accessible? ☐ **Yes** ☐ **No** **Is this office accessible to public transportation?** ☐ **Yes** ☐ **No**

C. LANGUAGES

Identify the foreign language(s) or sign language for which you have <u>fluent</u> clinicians at this location.
(Put an 'X' in no more than 5):

☐ American Sign Language (SG)	☐ French (FR)	☐ Italian (IT)	☐ Russian (RU)
☐ Arabic (AR)	☐ German (GE)	☐ Japanese (JA)	☐ Spanish (SP)
☐ Armenian (AN)	☐ Greek (GR)	☐ Korean (KO)	☐ Swedish (SW)
☐ Chinese (CH)	☐ Hebrew (HE)	☐ Norwegian (NW)	☐ Tagalog/Filipino (PH)
☐ Dutch (DU)	☐ Hindi (HI)	☐ Polish (PL)	☐ Vietnamese (VI)
☐ Farsi (FA)	☐ Hungarian (HU)	☐ Portuguese (PO)	☐ Yiddish (YI)
		☐ Other (OT): _____	

Name of Practice Location_____ Date:_____

D. CLINICAL EXPERTISE (SPECIALTIES): Please indicate **specialty areas** for which you have training and expertise at this location. These specialties will be used to assist *The CT Behavioral Health Partnership* in making clinically appropriate referrals. Please remember to put an 'X' the applicable specialties when applying for the specialty networks.

CLINICAL EXPERTISE	Please put 'X' in applicable specialties.	**THERAPEUTIC MODALITIES**	Please put 'X' in applicable specialties.
Addictions, Non-Chemical		Critical Incident Stress Management	
Addictions, Chemical		**Eye Movement Desensitization and Reprocessing (EMDR)**	
Anger Management/Impulse Disorders		Neuropsychological Testing	
Attention Deficit Hyperactivity Disorder		Play Therapy	
Applied Behavioral Analyst		Psych Testing	
Autistic Disorder / Asperger Syndrome		Psychopharmacology	
Chronic Pain			
Eating Disorders			
Faith Based Counseling			
Forensics/Criminal Justice			
Gangs/Cults			
Gay/Lesbian/Bisexual Issues			
Geropsychiatry/Alzheimer's			
Head Trauma			
Hearing Impaired			
HIV / AIDS			
Mental Retardation / Developmental Disabilities			
Military Lifestyle Issues			
Panic/Phobias			
Perinatal Mental Health			
Physical Abuse Perpetrators			
Physical Abuse Victims			
Post-Traumatic Stress Disorder			
Reactive Attachment Disorder			
Schizophrenia			
Transgender			

Name of Practice Location_____ Date:_____