UnitedHealthcare Community Plan of Tennessee
Behavioral Health Facility Credentialing Application: Short

Read these instructions carefully. It is strongly recommended that you conduct an administrative review to help ensure that your application complies with all instructions. Failure to complete the application thoroughly could result in the delay of your credentialing process.

All applicants must complete this application. Page 6 must be signed by the individual authorized to attest to the information submitted on behalf of the entity. Please enter the date and identify the name of the individual authorized to attest to the information submitted on behalf of the entity named on page 2.

In addition, the preparation checklists are not intended to be an all-inclusive repetition of the required application contents and associated application preparation guidelines. They are meant to highlight certain critical items so they will not be overlooked when the application is prepared.

Completed application should be returned by email to

uhccp_bhnetwork@uhc.com

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TennCare Facility Short Credentialing Application

Are you currently in the UnitedHealthcare network? ☐ Yes ☐ No

If yes, in which networks are you currently participating?

☐ Commercial ☐ Medicaid ☐ Medicare ☐ Other ______________________

Acceptance into the UnitedHealthcare care provider network is contingent upon the applicant Facility meeting our credentialing standards and subject to review and approval by the Credentialing Committee. We collect updated credentialing documents approximately every 36 months. The requested information is required in order to comply with our credentialing standards and continue your participation in the network. Additionally, the information you provide will help ensure the accuracy of claims payment.

ORGANIZATIONAL FACILITY IDENTIFYING INFORMATION

Legal Name of Facility ______________________

Parent Company/Health System Name (if applicable) ______________________

DBA (Identifying) Name ______________________

Administrative Address ______________________

City, State, ZIP ______________________ County ______________________

Administrative Phone ______________________ Fax ______________________ Email ______________________

Website ______________________

Tax ID Number ______________________

NPI Number Primary ______________________ Secondary ______________________

Billing / Remit Address ______________________

City, State, ZIP ______________________

IDENTIFY LEVELS OF CARE YOU DESIRE TO ADD TO YOUR CONTRACT

Levels of care require appropriate state licensure and/or certification to be provided as part of this application

Psychiatric / Mental Health	Adult	Geriatric	Adolescent	Child
I/P Locked				
I/P Open				
Residential				
Health Link				
Supportive Community Living				
Supportive Housing				
Enhanced Supportive Housing (Medically Fragile)				
Comprehensive Child & Family Treatment (CCFT)				
Continuous Treatment Team (CTT)				
Program of Assertive Community Treatment (PACT)				
Psychosocial Rehab Individual and/or Group				
Peer Support Individual and/or Group				
Illness Management Recovery Individual and/or Group				
Supported Employment				
Partial Hospitalization (PHP)				
MH Intensive Outpatient (IOP)				
Crisis Services (i.e. stabilization, 23 hr. obs.)				
ECT	☐ Inpatient ☐ Outpatient			

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Substance Use Disorder (SUD)/Chemical	Adult	Geriatric	Adolescent
Medically Managed Intensive Inpatient Services ASAM 4 ***LOCATION:*** *Acute care hospital only*			
Medically Monitored Intensive Inpatient Services ASAM 3.7 WM ***LOCATION:*** *Acute care or freestanding healthcare setting*			
Medically Monitored Intensive Inpatient Services (SUD Inpatient) ASAM 3.7 ***LOCATION:*** *Acute care or freestanding healthcare setting*			
Clinically Managed High-Intensity Residential Services (SUD Residential) ASAM 3.5 ***LOCATION:*** *Therapeutic Community; freestanding healthcare setting*			
Partial Hospitalization (PHP) – ASAM 2.5			
SUD Intensive Outpatient (IOP) – ASAM 2.1			
Ambulatory Detox (Drug or Alcohol) – ASAM 1 WM			
Outpatient Clinic – ASAM 1			
Opioid Treatment Program			
Other:			

IDENTIFY PRACTICE LOCATIONS(S) ONLY FOR ABOVE CHECKED LEVEL(S) OF CARE

Facility Location(s)	Age Category/Population	Mental Health						Substance Use Disorder							
		Acute Inpatient	Residential	Partial Hospitalization	Intensive Outpatient	Case Management CCFT, CTT	* Other ___	Medically Managed Intensive Inpatient Services ASAM 4	Medically Monitored Intensive Inpatient Services ASAM 3.7 WM	Medically Monitored Intensive Inpatient Svc. (SUD Inpatient) ASAM 3.7	Clinically Managed High-Intensity Residential Services (SUD Residential) ASAM 3.5	Partial Hospitalization ASAM 2.5	Intensive Outpatient ASAM 2.1	Ambulatory Detox (Drug or Alcohol) ASAM 1 WM	* Other ___
Location #1															
	Adult														
	Geri														
	Adol														
Admission	Child														
Phone:		**# of IP Beds (MH):**						**# of IP Beds (SUD):**							
Secure Fax:		**# of Medicare Acute IP Beds (MH):**													
Location #2															
	Adult														
	Geri														
	Adol														
Admission	Child														
Phone:		**# of IP Beds (MH):**						**# of IP Beds (SUD):**							
Secure Fax:		**# of Medicare Acute IP Beds (MH):**													

* **If additional space is needed to add "Other" services, please print additional copies of this page and continue to insert services in the "Other" column.**

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ORGANIZATIONAL PROVIDER CONTACT INFORMATION

	Name	Phone	Email Address
Primary Contact			
Signatory Contact			
Facility Contracting Contact			
Administrator/Roster Contact			
Business Office Manager			
Director of Clinical Services			
Medical Director			
Chief Executive Officer			

ACCREDITATION

(Applicable to additional Level(s) of Care only)

	Issue Date	Expiration Date	Not Applicable
The Joint Commission			
Commission on Accreditation of Rehabilitation Facilities (CARF)			
American Osteopathic Association (AOA)			
Council on Accreditation (COA)			
Community Health Accreditation Program (CHAP)			
Center for Improvement in Healthcare Quality (CIHQ)			
American Association for Ambulatory Health Care (AAAHC)			
Critical Access Hospitals (CAH)			
Healthcare Facilities Accreditation Program (HFAP, through AOA)			
National Integrated Accreditation for Healthcare Organizations (NIAHO, through DNV Healthcare)			
Accreditation Commissions for Healthcare (ACHC)			
Please list other Accreditation held by your organization			

COMMISSION of ACCREDITATION of REHABILITATION FACILITIES (CARF)

ASAM LEVEL OF CARE CERTIFICATION(S) (if applicable)

☐ ASAM Level 3.1 (Adult) ☐ ASAM Level 3.5 (Adult) ☐ ASAM Level 3.7 (Adult)

LICENSURE/CERTIFICATION

(Only include for the Level(s) of Care being added to contract)

Entity Issuing License or Certification	Type of License or Certificate	License Number	Expiration Date
1.			
2.			
3.			
4.			

Does the organizational provider state licensure/certification include a site visit by the state? ☐ Yes ☐ No

If "Yes", please attach a copy of the audit completed by the state with this application.

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MEDICARE/MEDICAID					
	Number		Issue Date	Expiration Date	Not Applicable
Medicare ID Number (6 digits)	Primary				
(Must include Medicare # validation from CMS)	Secondary				
Medicaid ID Number	Primary				
(Must include Medicaid # validation from applicable state entity)	Secondary				

GENERAL/PROFESSIONAL LIABILITY

Please attach current certificates for two types of liability insurance information. UnitedHealthcare insurance requirements are as follows:

For facilities/programs **with** an acute inpatient component:

Professional/general liability $5,000,000/$5,000,000 minimum coverage

For facilities/programs **without** an acute inpatient component:

Professional liability $1,000,000/$3,000,000 minimum coverage

Comprehensive general liability $1,000,000/$3,000,000 minimum coverage

Professional Liability Limits: ______________________ **General Liability Limits:** ______________________

If you are self-insured, we require the portion of the facility's independently audited financial statement which shows retention of the required amounts stated above.

LOCATION ACCESSIBILITIES

(please complete for all conditions that apply)

	Days	Hours	Not Applicable
Standard Business Operating Hours			
Evening Hours (any hours after 5 p.m.)			
Weekend Hours (Saturday or Sunday)			
TDD Capability			
Public Transportation Access			
Wheelchair/Handicap Accessibility			

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SIGNATURE

I hereby certify that all the responses and information provided, pursuant in this application, are complete, true and correct to the best of my knowledge and belief. I further warrant that the Facility's applicable licensure(s) is current and free of sanction or limitation. I understand that the Facility is responsible for adherence to UnitedHealthcare's credentialing requirements, clinical guidelines and other processes and procedures as outlined at **UHCprovider.com**. I warrant that I have the authority to sign this application on behalf of the entity for which I am signing in representative capacity. I warrant that I (or my designee) have reviewed and will consistently review the level of care guidelines associated with services being credentialed. The level of care guidelines can be found at **UHCprovider.com**.

______________________________	______________________________
Signature	**Date**
______________________________	______________________________
Name (please type or print)	**Title (please type or print)**

PREPARATION CHECKLIST

Please provide the following documents:

- ☐ Current State License(s)/Certificates(s) for all behavioral health services you provide (i.e., psychiatric, substance abuse, residential, intensive outpatient, etc.) A18 – include all documentation for multiple facility locations.
- ☐ Accreditation status (i.e., The Joint Commission, CARF, COA, etc.)
- ☐ Medicare certification letter with Medicare number (**REQUIRED** if applying for participation in Medicare networks)
- ☐ Clinical Program Description – including any specialty program descriptions and hours per day/days per week
- ☐ Staff Roster for all behavioral health staff involved with your programs. Please list their degrees, licenses and/or certificates. We do not need an actual copy of their licenses or certifications.
- ☐ Daily Program Schedule(s) – include an hour-by-hour schedule showing a patient's daily treatment for each level of care you provide. Include weekend scheduling, where appropriate.
- ☐ Copy of completed Ownership & Disclosure Form (**REQUIRED** if applying for participation in Medicaid networks)
- ☐ Professional and General liability insurance certificates showing limits, policy number(s) and expiration date(s). If self-insured, attach a copy of an independently audited financial statement which shows retention of the required amounts.
- ☐ W-9 form: If multiple tax ID numbers used, one W-9 must be submitted for each (NOTE: required if adding or changing tax ID number or entity name)

Policies and Procedures (as applicable)

- ☐ Policy and Procedure on Intake/Access Process to Behavioral Medicine
- ☐ Policy and Procedure on Intake/Access Process if done through ER
- ☐ Policy and Procedure on Holds/Restraints
- ☐ Policy and Procedure for Discharge Planning

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FACILITY TYPE INFORMATION

Identify what best describes your organization:

MH	SUD		MH	SUD		MH	SUD	
☐	☐	Freestanding Day Treatment	☐	☐	Ambulatory Detox (Alcohol)	☐	☐	Rural Health Clinic
☐	☐	Freestanding IOP	☐	☐	General Acute Hospital with Detox	☐	☐	Outpatient Detox Center
☐	☐	General Acute Care Hospital	☐	☐	Psychiatric Residential Facility	☐	☐	SUD Recovery Home
☐	☐	Freestanding Psychiatric Hospital	☐	☐	Community Mental Health Center	☐	☐	SUD Rehabilitation Facility
☐	☐	Residential Treatment Center	☐	☐	Home Health Care Agency	☐	☐	SUD Residential Facility
☐	☐	Ambulatory Detox (Drug)	☐	☐	Facility Opioid Treatment Center	☐	☐	Other ____________

STAFFING

(applicable to additional level(s) of care only)

Please answer the following questions relating to your professional psychiatry staff:

1. Are services by psychiatrists restricted to staff/faculty psychiatrists? ☐ Yes ☐ No
2. Number of board-certified psychiatrists on staff: ____________
3. Indicate the number of psychiatrist visits per week by level of care:

	IP Acute	Medically Managed Intensive Inpatient Services ASAM 4	Medically Monitored Intensive Inpatient Services ASAM 3.7 WM	SUD Inpatient ASAM 3.7	Clinically Managed High Intensity Residential Services (SUD Residential) ASAM 3.5	MH Residential	Partial Hospital-ization ASAM 2.5	MH PHP	Intensive Outpatient Services ASAM 2.1	MH IOP
Number of visits by MD										
Number required in Facility bylaws or policy										

Additional Questions:

1. How often is individual therapy provided? ____________
2. How often is family therapy provided? ____________
3. What is the patient/staff ratio? ____________
4. What is the staff position responsible for discharge planning? ____________
5. Describe your discharge planning procedures:

   ____
6. What percentage of patients is referred for follow-up care? ____________
7. What are your protocols for psych testing?

   ____
8. For the partial hospital and IOP services, does the program serve as a step-down or are patients directly admitted?

   ____

   8.1 Does your partial hospital or IOP program align with ASAM, LOCUS, CASII, and/or ECSII, as applicable?? ☐ Yes ☐ No
9. What percentage of patients is directly admitted to the partial and IOP programs? ____________

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10. What components are present in your Substance Use Disorder programs?
    - ☐ No SUD services offered
    - ☐ Education is directed to drug of choice
    - ☐ Relapse prevention is part of program
    - ☐ Program meets Department of Transportation requirements
    - ☐ There are criteria for drug/alcohol urine screens
11. Please identify your Average Length of Stay (ALOS) for each program (applicable to additional level(s) of care only)

ALOS	Mental Health Services	ALOS	Substance Use Disorder Services
	Locked		Medically Managed Intensive Inpatient Services (ASAM 4)
	Acute		Medically Monitored Intensive Inpatient Service (ASAM 3.7 WM)
	Residential		Medically Monitored Intensive Inpatient Svcs. (SUD Inpatient) (ASAM 3.7)
	Partial Hospitalization		Clinically Managed High-Intensity Residential Services (SUD Residential) (ASAM 3.5)
	Intensive Outpatient		Partial Hospitalization (ASAM 2.5)
	Other:		Intensive Outpatient (ASAM 2.1)
			Ambulatory Detox/Withdrawal Management Services (ASAM 1 WM)

12. Are there any programs/departments within the facility managed by external organizations (i.e., emergency room, specialty programs)? ☐ Yes ☐ No

Facility Dept or Program	Organization Name	Address	Contact Name	Phone

SERVICE DELIVERY/SPECIALTY SERVICES

1. If Medically Managed Intensive Inpatient (ASAM 4) is offered at the facility, please identify, with a check mark, the physical location of beds:

   ☐ **Bed located on a medical floor/unit** ☐ **Bed located on a behavioral health floor/unit**
2. If the facility offers partial hospitalization and/or intensive outpatient programs, please indicate number of hours of treatment per day and how many days per week (please review our clinical requirements at **UHCprovider.com**):

   Full-day Partial ______________ **Intensive Outpatient** ______________
3. If the facility offers both ASAM 3.5 and ASAM 3.7, is the facility aware of the differences in the clinical requirements between the two levels of care? ☐ Yes ☐ No
4. Does facility offer Medication-Assisted Treatment (MAT) in the following levels of care:

	Available	Not Available
Medically Monitored Intensive Inpatient Services ASAM 3.7 WM		
Medically Monitored Intensive Inpatient Svcs. (SUD Inpatient) ASAM 3.7		
Clinically Managed High-Intensity Residential Services (SUD Residential) ASAM 3.5		

	Available	Not Available
PHP ASAM 2.5		
IOP ASAM 2.1		
Ambulatory Detox ASAM 1		

   Medications: ______________
5. Please indicate if the facility is able to accommodate the following membership needs in your service area:

	Available	Not Available	Accommodation Method
Member language needs			
Member handicap needs			

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a. Are all locations handicapped-accessible? ☐ Yes ☐ No

If "No", please indicate which location(s) would not meet the criteria for handicapped accessibility:

____

6. Please identify only new specialty(ies) you are seeking to add:

	Available	**Not Available**	**Location(s)**	**Comments / Descriptions**
Eating Disorder Treatment - Inpatient				
Electroconvulsive Therapy (ECT) - Inpatient				
Electroconvulsive Therapy (ECT) - Outpatient				
Dual Diagnosis Services				
Continuing Day Treatment				
LGBT Services				
Domiciliary Services in an IOP or PHP Setting (program must be formally approved by Plan)				
Chronically Mentally Ill Services (CMI)/Severely Mentally Ill Services (SMI)				
Respite Care Services				
Emergency Room Services (assessment only)				
23-Hour Crisis Observation				
Mobile Crisis Stabilization				
MH/SUD Outpatient Clinics in a Hospital				
Medication-Assisted Treatment (MAT) – available in requested levels of care (Must meet state of TN state program requirements) Type:				
Sober Living/Supervised Living				
Halfway House				
Group Home				
Therapeutic Foster Care				
ASAM Residential Services *3.1 – Clinically Managed Low-Intensity Res.*				

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