

Behavioral Health Facility Credentialing Application

Is your facility already contracted with UnitedHealthcare?

Yes

No

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.

Completed application should be returned by email to WABHContracts@uhc.com

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 FACILITY DESIRES TO CONTRACT

UnitedHealthcare participating care providers: only select the level(s) of care being added to contract

Psychiatric/Mental Health	Geriatric	Adult	Adolescent	Child
I/P Locked	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I/P Open	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Residential	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Partial Hospitalization (PHP)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
MH Intensive Outpatient (IOP)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crisis Services (i.e., stabilization, 23-hour Ob)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ECT	<input type="checkbox"/> Inpatient		<input type="checkbox"/> Outpatient	

Substance Use Disorder/Chemical Dependency	Geriatric	Adult	Adolescent
Medically Managed Intensive Inpatient Services ASAM 4 <i>LOCATION: Acute care hospital only</i>			
Medically Monitored intensive Inpatient Services ASAM 3.7 WM <i>LOCATION: Acute care or freestanding healthcare setting</i>			
Medically Monitored Intensive Inpatient Services (SUD Inpatient) ASAM 3.7 <i>LOCATION: Acute care or freestanding healthcare setting</i>			
Clinically Managed High-Intensity Residential Services (SUD Residential) ASAM 3.5 <i>LOCATION: Therapeutic Community; freestanding health care setting</i>			
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 LOCATION(S) ONLY FOR ABOVE CHECKED LEVEL(S) OF CARE

Facility Location(s)	Age Category/ Population Treated	Mental Health					Substance Use Disorder									
		Acute Inpatient	Residential	Partial Hospitalization	Intensive Outpatient	Crisis Services	*Other _____	Medically Managed Intensive Inpatient Services ASAM 4	Medically Monitored Intensive Inpatient Services ASAM 3.7 WM	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) AASAM 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):														

Location #3														
	Adult													
	Geri													
	Adol													
Admission	Child													
Phone:		# of IP Beds (MH):					# of IP Beds (SUD):							
Secure Fax:		# of Medicare Acute IP Beds (MH):												

Location #4														
	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.

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			
If you do not have accreditation, a site visit will be required.			
	Issue Date	Expiration Date	Not Applicable
The Joint Commission			<input type="checkbox"/>
Commission on Accreditation of Rehabilitation Facilities (CARF)			<input type="checkbox"/>
American Osteopathic Association (AOA)			<input type="checkbox"/>
Council on Accreditation (COA)			<input type="checkbox"/>
Community Health Accreditation Program (CHAP)			<input type="checkbox"/>
Center for Improvement in Healthcare Quality (CIHQ)			<input type="checkbox"/>
American Association for Ambulatory Health Care (AAAHC)			<input type="checkbox"/>
Critical Access Hospitals (CAH)			<input type="checkbox"/>
Healthcare Facilities Accreditation Program (HFAP, through AOA)			<input type="checkbox"/>
National Integrated Accreditation for Healthcare Organizations (NIAHO, through DNV Healthcare)			<input type="checkbox"/>
Accreditation Commissions for Healthcare (ACHC)			<input type="checkbox"/>
Please list other Accreditation held by your organization			

COMMISSION of ACCREDITATION of REHABILITATION FACILITIES (CARF)				
ASAM LEVEL OF CARE CERTIFICATION(S) (if applicable)				
<input type="checkbox"/> ASAM Level 3.1 (Adult)	<input type="checkbox"/> ASAM Level 3.5 (Adult)	<input type="checkbox"/> ASAM Level 3.7 (Adult)		
LICENSURE/CERTIFICATION				
(UnitedHealthcare participating care providers, 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.



MEDICARE/MEDICAID				
	Number	Issue Date	Expiration Date	Not Applicable
Behavioral Health Medicare ID Number (6 digits) (Must include Medicare # validation from CMS)	Primary			<input type="checkbox"/>
	Secondary			
Medicaid ID Number (Must include Medicaid # validation from applicable state entity)	Primary			<input type="checkbox"/>
	Secondary			

LOCATION ACCESSIBILITIES (please complete all conditions that apply)			
	Days	Hours	Not Applicable
Standard Business Operating Hours			<input type="checkbox"/>
Evening Hours (any hours after 5 p.m.)			<input type="checkbox"/>
Weekend Hours (Saturday or Sunday)			<input type="checkbox"/>
TDD Capability			<input type="checkbox"/>
Public Transportation Access			<input type="checkbox"/>
Wheelchair/Handicap Accessibility			<input type="checkbox"/>

SIGNATURE

I hereby certify that all of 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 the 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)

FACILITY TYPE INFORMATION

Identify what best describes your organization:

MH SUD

- Freestanding Day Treatment
- Freestanding IOP
- General Acute Care Hospital
- Freestanding Psychiatric Hospital
- Residential Treatment Center
- Ambulatory Detox (Drug)
- Ambulatory Detox (Alcohol)

MH SUD

- General Acute Hospital with Detox
- Psychiatric Residential Facility
- Community Mental Health Center
- Home Health Care Agency
- Facility Opioid Treatment Center
- IHS Facility/Agency
- Rural Health Clinic

MH SUD

- Outpatient Detox Center
- SUD Recovery Home
- SUD Rehabilitation Facility
- SUD Residential Facility
- Skilled Nursing Facility
- Tribal 638 Facility/Agency
- Other _____

STAFFING

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 Hospitalization 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										

PREPARATION CHECKLIST

Please provide the following documents:

- Current State License(s)/Certificate(s) for all behavioral health services you provide (i.e., psychiatric, substance use disorder, 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 network)
- 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.

Policies and Procedures (ONLY NEEDED FOR NEW FACILITY APPLICANTS):

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

COMPENSATION

Indicate your current retail rates and approximate discounted contracted rates for each level of care on a per diem basis, exclusive or inclusive of professional fees:

Mental Health		
Level of Care	Retail	Discount
IP Locked		
IP Acute		
Residential		
Full-day Partial		
Intensive OP		
ECT - Outpatient		
ECT - Inpatient		

Substance Use Disorder Chemical Dependency		
Level of Care	Retail	Discount
Medically Managed Intensive Inpatient Services ASAM 4		
Medically Monitored Intensive Inpatient Services ASAM 3.7 WM		
Medically Monitored Intensive Inpatient Services (SUD Inpatient) ASAM 3.7		
Clinically Managed High-Intensity Residential Services (SUD Residential) ASAM 3.5		
Full-day Partial ASAM 2.5		
Intensive OP ASAM 2.1		
Ambulatory Detox ASAM 1 WM		

Please identify any other behavioral health services that are provided by the facility with rate information:

Service Type	Retail Rate	Discount Rate	Comments

DELIVERY OF CARE

Please answer the following questions relating to your policy and procedures as identified:

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 are 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? _____
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

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

If "Yes", please provide the following:

Facility Dept. or Program	Organization Name	Address	Contact Name	Phone

SERVICE DELIVERY/SPECIALTY SERVICES

If Medically Managed Intensive Inpatient (ASAM 4) is offered at the facility, please identify, with a check mark, the

1. physical location of beds:

Bed located on a medical floor/unit Bed located on a behavioral health unit

If 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 clinical requirements at UHCprovider.com):

Full-Day Partial _____ Intensive Outpatient _____

3. If Facility offers both ASAM 3.5 and ASAM 3.7, is 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		Available	Not Available
Medically Monitored Intensive Inpatient Services ASAM 3.7 WM	<input type="checkbox"/>	<input type="checkbox"/>	PHP ASAM 2.5	<input type="checkbox"/>	<input type="checkbox"/>
Medically Monitored Intensive Inpatient Svcs. (SUD Inpatient) ASAM 3.7	<input type="checkbox"/>	<input type="checkbox"/>	IOP ASAM 2.1	<input type="checkbox"/>	<input type="checkbox"/>
Clinically Managed High-Intensity Residential Services (SUD Residential) ASAM 3.5	<input type="checkbox"/>	<input type="checkbox"/>	Ambulatory Detox ASAM 1	<input type="checkbox"/>	<input type="checkbox"/>

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	<input type="checkbox"/>	<input type="checkbox"/>	_____
Member handicap needs	<input type="checkbox"/>	<input type="checkbox"/>	_____

- a. Are all locations handicapped accessible? Yes No

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

6. Identify specialty services offered:	Available	Not Available	Location(s)	Comments / Descriptions
Eating Disorder Treatment – Inpatient	<input type="checkbox"/>	<input type="checkbox"/>		
Electro-convulsive Therapy (ECT) - Inpatient	<input type="checkbox"/>	<input type="checkbox"/>		
Electro-convulsive Therapy (ECT) – Outpatient	<input type="checkbox"/>	<input type="checkbox"/>		
Dual Diagnosis Services	<input type="checkbox"/>	<input type="checkbox"/>		
Continuing Day Treatment	<input type="checkbox"/>	<input type="checkbox"/>		
LGBT services	<input type="checkbox"/>	<input type="checkbox"/>		
Domiciliary Services in an IOP or PHP setting (program must be formally approved by Plan)	<input type="checkbox"/>	<input type="checkbox"/>		
Chronically Mentally Ill Services (CMI)/Severely Mentally Ill Services (SMI)	<input type="checkbox"/>	<input type="checkbox"/>		
Respite Care Services	<input type="checkbox"/>	<input type="checkbox"/>		
Emergency Room Services (assessment only)	<input type="checkbox"/>	<input type="checkbox"/>		
Twenty-three (23) Hour Crisis Observation	<input type="checkbox"/>	<input type="checkbox"/>		
Mobile Crisis Stabilization	<input type="checkbox"/>	<input type="checkbox"/>		
MH/SUD Outpatient Clinics in a hospital	<input type="checkbox"/>	<input type="checkbox"/>		
Identify specialty services offered (cont.):	Available	Not Available	Location(s)	Comments / Descriptions
Medication-Assisted Treatment (MAT) – available in requested levels of care Type:	<input type="checkbox"/>	<input type="checkbox"/>		
Sober Living/Supervised Living	<input type="checkbox"/>	<input type="checkbox"/>		
Halfway House	<input type="checkbox"/>	<input type="checkbox"/>		
Group Home	<input type="checkbox"/>	<input type="checkbox"/>		
Therapeutic Foster Care	<input type="checkbox"/>	<input type="checkbox"/>		
Community-based Acute Treatment for Children and Adolescents (CBAT)	<input type="checkbox"/>	<input type="checkbox"/>		
Intensive Community-based Acute Treatment for Children and Adolescents (ICBAT)	<input type="checkbox"/>	<input type="checkbox"/>		
ASAM Residential Services 3.1 – Clinically Managed Low Intensity Res.	<input type="checkbox"/>	<input type="checkbox"/>		