Behavioral Health Facility Integrated 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 being approved by the Credentialing Committee. We collect updated documentation in order to recredential facilities approximately every 36 months. The requested information is required in order to comply with our credentialing standards and continue your participation in the network.

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	☐	☐	☐	☐
I/P Open	☐	☐	☐	☐
Residential	☐	☐	☐	☐
Partial Hospitalization (PHP)	☐	☐	☐	☐
MH Intensive Outpatient (IOP)	☐	☐	☐	☐
Crisis Services (i.e., stabilization, 23-hour Ob)	☐	☐	☐	☐
ECT	☐ Inpatient		☐ Outpatient	

Substance Use Disorder/Chemical Dependency	Geriatric	Adult	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*			

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Clinically Managed High-Intensity Residential Services (SUD Residential) ASAM 3.5 ***LOCATION:*** *Therapeutic Community; freestanding health care 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 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):**													

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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.**

WHEELCHAIR/HANDICAP ACCESSIBILITY		
Do locations shown on page 2 offer wheelchair/handicap accessibility?		
Location #1	☐ Yes	☐ No
Location #2	☐ Yes	☐ No
Location #3	☐ Yes	☐ No
Location #4	☐ Yes	☐ No

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			

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

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)** _____

PREPARATION CHECKLIST

Please provide the following documents:

- ☐ Current State License(s)/Certificate(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.
- ☐ W9 form: If multiple tax ID numbers used, one W9 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

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FACILITY TYPE INFORMATION

Identify what best describes your organization:

MH	SUD		MH	SUD		MH	SUD	
☐	☐	Freestanding Day Treatment	☐	☐	General Acute Hospital with Detox	☐	☐	Outpatient Detox Center
☐	☐	Freestanding IOP	☐	☐	Psychiatric Residential Facility	☐	☐	SUD Recovery Home
☐	☐	General Acute Care Hospital	☐	☐	Community Mental Health Center	☐	☐	SUD Rehabilitation Facility
☐	☐	Freestanding Psychiatric Hospital	☐	☐	Home Health Care Agency	☐	☐	SUD Residential Facility
☐	☐	Residential Treatment Center	☐	☐	Facility Opioid Treatment Center	☐	☐	Skilled Nursing Facility
☐	☐	Ambulatory Detox (Drug)	☐	☐	IHS Facility/Agency	☐	☐	Tribal 638 Facility/Agency
☐	☐	Ambulatory Detox (Alcohol)	☐	☐	Rural Health Clinic	☐	☐	Other _____

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

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SERVICE DELIVERY/SPECIALTY SERVICES				
Identify specialty services offered:	**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)	☐	☐		
Twenty-three (23)-Hour Crisis Observation	☐	☐		
Mobile Crisis Stabilization	☐	☐		
MHSA Outpatient Clinics in a hospital	☐	☐		
Medication-Assisted Treatment (MAT) – available in requested levels of care Type:	☐	☐		
Sober Living/Supervised Living	☐	☐		
Halfway House	☐	☐		
Group Home	☐	☐		
Therapeutic Foster Care	☐	☐		
Community-based Acute Treatment for Children and Adolescents (CBAT)	☐	☐		
Intensive Community-based Acute Treatment for Children and Adolescents (ICBAT)	☐	☐		
ASAM Residential Services *3.1 – Clinically Managed Low-Intensity Res.*	☐	☐		

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