BEHAVIORAL HEALTH
PROVIDER RECREDENTIALING APPLICATION

Please return these materials to update your Companion Benefit Alternatives (CBA) provider file. You must return all materials within the time frame specified.

APPLICATION CHECKLIST:

[ ] Completed application
[ ] Companion Benefit Alternative (CBA) Professional Agreement [ ]
Copy of state license.
[ ] Copy of Drug Enforcement Administration (DEA) license (if applicable). [ ]
Copy of board certification (if applicable).
[ ] Copy of protocol (advanced practice registered nurses). [ ]
Proof of current malpractice coverage.*

*Coverage minimums vary: Medical Doctors = JUA/PCF[1] or $1,000,000/$3,000,000
All others = $1,000,000/$1,000,000

CBA is a separate company that provides behavioral health benefits on behalf of BlueChoice® HealthPlan and BlueCross® BlueShield® of South Carolina. BlueCross BlueShield of South Carolina and BlueChoice HealthPlan are an independent licensees of the Blue Cross and Blue Shield Association.

Please enclose all information and allow at least 30 days for processing before checking on the application status. We cannot process applications until we receive all information. Retain a copy of all application materials for your records.

Return Application To:

Credentialing Specialist – AX310
P.O. Box 6170
Columbia, SC 29202
FAX 803-870-9997

[1] JUA = Joint Underwriting Association; PCF = Patient Compensation Fund

A. Personal Profile *(Please print or type.)*

Full Name:		**License: [ ] MD/DO [ ] Psychologist [ ] APRN [ ] LPC [ ] LISW-CP [ ] LMFT [ ] PA**	
Date of Birth:	**Social Security Number (SSN):**	**Individual National Provider Identifier (NPI):**	**Medicaid #:**
Race/Ethnicity (optional)**: [ ] African American [ ] Asian Indian [ ] Native American [ ] Pacific Asian [ ] White, non-Hispanic [ ] Other _____ [ ] Ethnicity _____**		**Gender (optional): [ ] Male [ ] Female**	

B. Office Information

1. Primary Office Address		**2. Additional Office Address** *(Please attach another page if you have additional locations.)*	
Group/Practice Name:		Group/Practice Name:	
*Tax ID# (TIN):	TIN Type: [ ] SSN [ ] Employer ID Number (EIN)	*TIN:	TIN Type: [ ] SSN [ ] EIN
Group NPI:		Group NPI:	
Physical Address:		Physical Address:	
Mailing Address:		Mailing Address:	
Billing/Remit Address: Billing Office Phone:		Billing/Remit Address: Billing Office Phone:	
Email Address:		Email Address:	
URL:		URL:	
Appointment Phone:		Appointment Phone:	
Fax:		Fax:	
Contact Name:	Phone:	Contact Name:	Phone:
Emergency Phone:		Emergency Phone:	
County:		County:	
Make Checks Payable to:		Makes Checks Payable to:	

**Complete a separate W9 form for each TIN. If you are changing your TIN, please submit the appropriate change forms to CBA.*

C. Office Profile

1. Practice type (check only one): [ ]
   Solo practice
   [ ] Group practice
   [ ] Other: _____

2. Practice Office Hours: [ ] Full Time [ ] Part Time
   Monday _____ to _____
   Tuesday _____ to _____
   Wednesday _ to ____ Thursday
   _____ to ____ Friday
   _____ to ____
   Other _____

3. Any additional languages spoken will be published to the provider directory to help members select providers who meet their language needs.

   Please list any language(s) other than English that you speak fluently: _____

4. Please list any language(s) other than English that clinical or office staff speaks:_____

5. Do you know sign language? [ ] Yes [ ] No TDD Phone#: _____

6. Are you accepting Medicaid patients? [ ] Yes [ ] No

7. Methods to provide emergency coverage 24/7 (check at least one): [ ] Live

   answering service
   [ ] Cell phone number is available to patients [ ]
   Pager number is available to patients
   [ ] Back-up clinician
   [ ] Referral to 24 hour psychiatric facility or nearest Emergency Room. [ ]
   Other – please explain:
   _____

8. Is your office accessible to the physically challenged? [ ] Yes [ ] No
   If no, what plan(s) have you made to relocate activities to a maximally accessible location. Please check one of these: [ ] Another office in my group is accessible and I will use this.
   [ ] Another location in my building is accessible and I will use this.
   [ ] I will use an office at another location. (Describe): _____

New Patient Accessibility

9. Are you currently accepting new patients? [ ] Yes [ ] No

10. Are you occasionally available for new patients to be seen the same day as the referrals? [ ] Yes [ ] No

11. Are you able to schedule an initial appointment within 10 working days of a call? [ ] Yes [ ] No
    If not, what is the average waiting time for initial appointments?
    [ ] 11-20 working days [ ] 21-30 working days [ ] More than 30 working days

Access Standard for Current Patients

12. For non-life-threatening situations that require face-to-face re-evaluation within six hours (i.e., the patient has a significant change in behavior resulting in the patient being unable to perform many day-to-day duties involving work, school, caring for family or taking care of basic needs, such as hygiene) (check all that apply):

    [ ] Telephone
    [ ] Face-to-face
    [ ] Back-up licensed clinician

13. For urgent situations that require face-to-face re-evaluation within 48 hours (i.e., the patient has a significant change in behavior resulting in the patient being unable to perform some day-to-day duties involving work, school, caring for family or taking care of basic needs, such as hygiene) (check all that apply) :

    [ ] Telephone
    [ ] Face-to-face
    [ ] Back up licensed clinician

14. For routine office visits (i.e., medication refill or supportive therapy), how soon can you see a current patient? [ ] Within

    10 working days (two weeks)
    [ ] Other (Please specify): _____

D. Clinical Profile – MDs/DOs ONLY

This Section is for Physicians Only.

1. Federal DEA #_____ State Equivalent (where applicable) _____

2. Board Status and Certification*
   [ ] I attest that my medical board status has not changed in the last three years. [ ] I attest that my areas of certification have not changed in the last three years. **My next recertification date will be:** _____

   *If any changes, please indicate in the space provided.

3. Hospital Privileges:
   [ ] I attest that my hospital privileges have not changed in the last three years.
   [ ] I attest that my hospital privileges have changed in the last three years. (Information supplied)

Primary Privileges:	Other Privileges:	Other Privileges:
Address:	Address:	Address:
Phone:	Phone:	Phone:

4. Are your hospital privileges still active and in good standing? [ ] Yes [ ] No

5. If you do not have active admitting privileges, please verify how you handle acute care.

_____

_____

6. Please list any specialized training or experience that you have acquired in the last three years.

E. Provider Areas of Expertise

1. Please indicate your top **10** areas of expertise. We will list these specialties with your name in our provider directory.

[ ]	ABA	**Behavioral Therapy for Autism Disorders**
[ ]	ABU	**Abuse, Assault and Trauma (PTSD)**
[ ]	ADD	**Attention Deficit Disorder (ADD/ADHD)**
[ ]	ADP	**Adoption**
[ ]	AP	**Anxiety and Panic Disorders**
[ ]	ASD	**Autism Spectrum Disorders (ASD/PPD/Asperger)**
[ ]	BAR	**Bariatric Assessment**
[ ]	BEH	**Behavior Modification**
[ ]	BPD	**Bipolar Disorders/Manic Depressive Illness**
[ ]	BSF	**Brief Solution Focused**
[ ]	CBT	**Cognitive Behavioral Therapy (CBT)**
[ ]	CD	**Chemical Dependency/Chemical Dependency Assessment**
[ ]	CHR	**Christian Counseling**
[ ]	DBT	**Dialectical Behavioral Therapy (DBT)**
[ ]	DEP	**Depression**
[ ]	DIV	**Divorce/Blended Family Issues**
[ ]	EAT	**Eating Disorders**
[ ]	ECT	**Electroconvulsive Therapy (ECT)**
[ ]	ELI	**End-of-Life Issues**
[ ]	ETH	**Cultural/Ethnic Issues**
[ ]	FAM	**Family Therapy**
[ ]	GAM	**Compulsive Gambling**
[ ]	GER	**Geriatrics**
[ ]	GLB	**Gay/Lesbian/Bisexual Issues**
[ ]	GRP	**Group Therapy**
[ ]	HIV	**HIV/AIDS Related Issues**
[ ]	INF	**Infertility**
[ ]	MED	**Medication Management**
[ ]	MEN	**Men's Issues**
[ ]	NEU	**Neuropsychological Testing**
[ ]	OCD	**Obsessive Compulsive Disorders**
[ ]	PER	**Personality Disorders**
[ ]	PM	**Pain Management**
[ ]	PN	**Prenatal Issues**
[ ]	PP	**Postpartum Issues**
[ ]	SCH	**Schizophrenic Disorders**
[ ]	SEX	**Sexual Disorders**
[ ]	TRN	**Transgender Issues**
[ ]	TST	**Psychological Testing**
[ ]	WOM	**Women's Issues**

2. Please list specialized training or experience in any of these areas, or any additional professional certifications. (Do not use abbreviations.)

3. Please check the age group(s) to which you provide services:

[ ] Child (0-12 years) [ ] Adult (18-65)
[ ] Adolescent (13-17 years) [ ] Geriatric (65+)

4. Do you provide employee assistance program (EAP) services for First Sun EAP? _____Yes _____ No
   A. Do you have any of these specializations or certifications? Please attach copies of applicable certifications.

   [ ] Certified Employee Assistance Professional [ ]
   Critical Incident Training
   [ ] Alcohol/Drug Certification
   [ ] Other (Specify): _____

   B. Do you work with clients who have been referred to the EAP due to job performance issues? _____Yes _____No

Medication-Assisted Treatment (MAT) providers only:

1. Are you a certified SAMSHA medication-assisted treatment (MAT) waiver provider? [ ] Yes [ ] No
2. What is your current waiver patient limit? [ ] 30 [ ] 100 [ ] 275
3. Are you actively accepting new MAT patients? [ ] Yes [ ] No
4. Do you wish to have the MAT designation displayed in the directory? [ ] Yes [ ] No
5. Please list the location where you are accepting MAT patients:

Program Name	Street Address	City	State	Zip Code	Phone Number

We thank you for being a part of our networks. Although we will do everything to ensure there are no delays, the recredentialing process may take up to 120 days after receipt of the completed application to verify, review and obtain final approval.

As a practitioner undergoing the recredentialing process, it's important to know that you have specific rights designed to ensure transparency, fairness, and due process throughout the evaluation. Below is a summary of your rights during the recredentialing process:

1. You have the right to review information obtained from outside sources (e.g., state licensing boards) used to evaluate your recredentialing application. Note: *This does not include references, recommendations, or other peer-review protected information.*
2. You have the right to correct any erroneous information submitted by outside sources. If credentialing staff identify a discrepancy or cannot verify submitted information, they will notify you in writing. This notification will include:
    - The specific erroneous information
    - Instructions on how to correct it (format and submission process).
    - Where to send your corrections.
    - Timeframe for submitting corrections (21 days).

    Corrections must be submitted within 21 days of the date of the notification. We will document receipt of your corrected information in your recredentialing file.
3. You have the right to be informed of the status of your recredentialing application upon request. When requested, we will respond by phone or email within 7 calendar days and will include:
    - The date your completed application was received.
    - Any outstanding items needed for completion.
    - The expected date of the recredentialing decision.

Note: To exercise the above rights, please email your inquiries to CBA.Provrep@companiongroup.com..

You will be notified of the Credentialing Committee's or Medical Director's review decision via email within 10 calendar days of the determination.
We do not base recredentialing decisions on an applicant's race, ethnic/national identity, gender, age, sexual orientation or patient's insurance coverage in which the practitioner specializes.

F. Attestation

If you answer yes to any of these questions, please attach a written detailed explanation and any relevant documentation.

1.	Do you have any pending misdemeanor or felony charges?	[ ] Yes	[ ] No
2.	In the past three years, have you been convicted of a felony?	[ ] Yes	[ ] No
3.	In the past three years, has your license to practice in any jurisdiction ever been voluntarily or involuntarily denied, restricted, suspended, challenged, revoked, conditioned or otherwise limited?	[ ] Yes	[ ] No
4.	In the past three years, and up to and including the present, have you had any ongoing physical or mental impairment or condition that would make you unable, with or without reasonable accommodation, to perform the essential functions of a provider in your area of practice, or unable to perform those essential functions without a direct threat to the health and safety of others?	[ ] Yes	[ ] No
5.	Considering the essential functions of a provider in your area of practice, in the past three years, and up to and including the present, have you suffered from any communicable health condition that could pose a significant health and safety risk to your patients?	[ ] Yes	[ ] No
6.	In the past three years, have you been publicly reprimanded or disciplined by a professional licensing agency or board or are you aware of any pending investigations or complaints?	[ ] Yes	[ ] No
7.	In the past three years, has your DEA certification or state-controlled drug permit been restricted, revoked, voluntarily relinquished or otherwise limited?	[ ] Yes	[ ] No
8.	In the past three years, have any of your privileges or memberships at any hospital or institution been denied, suspended, reduced, revoked, voluntarily relinquished or otherwise limited?	[ ] Yes	[ ] No
9.	In the past three years, has your participation in Medicare, Medicaid or any other government program ever been limited or curtailed, or have you voluntarily excluded yourself from any of these programs?	[ ] Yes	[ ] No
10.	In the past three years, has your participation in an insurance company network ever been limited or terminated?	[ ] Yes	[ ] No
11.	In the past three years, have you had a history of chemical dependency or substance abuse that might affect your ability to competently and safely perform the essential functions of a provider in your area of practice?	[ ] Yes	[ ] No
12.	In the past three years, have you had or do you have any mental or physical condition or do you take any medications that might affect your ability to competently and safely perform the essential functions of a provider in your area of practice?	[ ] Yes	[ ] No
13.	In the past three years, has any malpractice carrier ever made an out-of-court settlement or paid a judgment of a medical malpractice claim on your behalf or have you ever been named in a malpractice suit that was settled, active or dismissed?	[ ] Yes	[ ] No
14.	In the past three years, has your professional liability insurer placed conditions or restrictions on your coverage of ability to obtain coverage?	[ ] Yes	[ ] No
15.	Are you aware of any potential malpractice suits that may be filed against you?	[ ] Yes	[ ] No

H. Consent

I understand that:

A. It is my responsibility to promptly advise CBA in writing within 30 days of any changes or additions to the information contained in this application.

B. This is an application only and my submission of this application does not automatically result in participation with CBA.

C. The CBA Professional Agreement is deemed effective on the date signed by the Director of CBA.

Notice: We will query the National Provider Data Bank if you apply. If we reject your application for reasons relating to professional conduct or professional competence, including misrepresenting, misstating or omitting a relevant fact in connection with your application, we may report the rejection to the National Provider Data Bank.

I, the undersigned, hereby attest that the information given in or attached to this application is accurate, complete and true; and fairly represents the current level of my training, experience, capability and competence to practice at the level requested. I specifically authorize CBA and its authorized representative to consult with any third party who may have information bearing on the subject addressed by this application and to inspect or obtain any reports, records, recommendations or other documents or disclosures of said third parties that may be material to the questions in this application. I also specifically authorize any such third parties to release said information to CBA and its authorized representatives upon request. I hereby release CBA and its authorized representative and any of such third parties, from any liability for any such reports, records, recommendations or other documents or disclosures involving me that are made, requested or received by CBA and/or its authorized representatives to, from or by any such third parties, including otherwise privileged or confidential information, made or given in good faith and relating to the subject matter addressed by this application.

In choosing to participate in the CBA Provider Network, the Undersigned represents and warrants the truth and accuracy of the statements made in his/her application, and CBA shall be entitled to rely upon such statements. CBA makes no representation or warranty concerning the truth and/or accuracy of any statements made by the participating Provider in his/her application or related materials.

If I am accepted for participation in CBA, I consent to CBA's inspection of my patient records as allowed by law necessary for its peer and utilization review and quality assessment purposes and agree to be bound by CBA's participation agreement, credentialing plan, policies and procedures.

A photocopy of this authorization shall be deemed equivalent to the original.

Any information you enter into this application that subsequently is found to be false could result in your dismissal from CBA's network.

_____ _____

Applicant ***Date***

You must sign the application in ink. Stamped signatures are not acceptable.

Practitioners have the right to:

1. Review information submitted to support the credentialing application.
2. Correct erroneous information.
3. To be informed of the status of the credentialing application.

To exercise the above rights, please email your inquiries to CBA.Provrep@companiongroup.com.