Partners
IN BEHAVIORAL HEALTH

PREFERRED PROVIDER APPLICATION SURVEY

Private or MD Practice Application*

Return to: Provider Relations
PARTNERS IN BEHAVIORAL HEALTH, LLC
34700 Valley Road
Oconomowoc, WI 53066

*Application survey completion does not imply acceptance by PBH.

GENERAL INFORMATION:

Provider Name: _____ Date of Birth: _____

Practice Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Telephone: _____ Fax: _____Individual NPI#: _____

Billing Name (if different): _____ Tax ID#: _____

_____

Office Manager: _____ Email:_____

EDUCATION/LICENSURE/CERTIFICATION:

1. Highest education degree: _____
   University/Medical School: _____ Year of Graduation: _____
2. State license/certification type: _____ No.: _____
   Initial date of receipt: _____ Expiration Date: _____
   (Include valid copy with expiration date)
3. Current licensure or certification in any other states? ☐ yes ☒ no
   Previous licensure or certification in any other stats? ☐ yes ☒ no
   If yes, list state(s) and type(s) of licensure/certification: _____
   _____
   Additional professional certification(s), membership(s) and affiliation(s): _____
   _____
   _____
   _____
4. Malpractice liability insurance amount: Incident/$_____ Aggregate/$_____
   Carrier: _____ Telephone: _____
   Expiration Date: _____ **(Include valid copy with expiration date)**
5. How many documented, formal complaints were received during the past twelve (12) months? _____
6. Usual fee per clinical hour: $_____

LEGAL STATUS:

- ☐ Private Practice
- ☐ Partnership
- ☐ Incorporated
- ☐ Other (clarify) XC

PROFESSIONAL CORPORATION (if applicable)

- ■ Professional Association (PA)
- ☐ Professional Service Corporation (PSC)
- ☐ Service Corporation (SC)

Is the organization:
- ■ Federal/State/County funded?
- ■ Not-for-profit?
- ☐ For-profit?

APPOINTMENT INFORMATION:

1. TTY/TTD (hearing-impaired services/capabilities)..... ☐ yes ■ no If yes, #_____
2. Public transportation access ..... ☐ yes ■ no
3. American sign language ..... ☐ yes ■ no
4. Handicap access ..... ☐ yes ■ no
5. Spanish speaking..... ☐ yes ■ no
6. Other bilingual services: _____
7. Indicate your regular days and hours of service: _____
   _____
8. Do you offer routine, initial appointment within one week? .. ☐ yes ■ no
   Same day in an emergency? ..... ☐ yes ■ no
9. Indicate all procedures used in handling urgent or emergency problems after normal hours:
   - ☐ beeper/paging service
   - ☐ 24-hour answering service
   - ☐ back-up coverage
   - ☐ outside facility
   - ☐ other (list and describe any special numbers to be used) _____
     _____
     _____

TREATMENT AVAILABILITY:

1. Current case load carried at practice for which you are applying: _____ No. per week: _____
2. Number of hours available per week for PBH patients: _____
3. Status at this practice:
   - ☐ full-time
   - ☐ part-time
   - ☐ consultant
   - ☐ employee
   - ☐ owner/partner

4. Indicate the makeup of your current practice by using the scale below:

4 – frequently *3 – occasionally* *2 – rarely* *1 – do not see*

	Mental Health	Substance Abuse
Adult	_____	_____
Adolescent	_____	_____
Child	_____	_____

5. What type of problem area(s) would you refer to another provider? _____
_____
_____

6. Estimate the number of referrals or patients you refer to other provider(s) per year: _____

7. Eliminating the highest and lowest cases, identify your usual utilization patterns:
   a. average number or sessions per case: _____
   b. percentage (total to equal 100%) of patients seen within: 1 to 7 sessions _____%
      8 to 15 sessions _____%
      16 to 23 sessions _____%
      over 23 sessions _____%
   c. average frequency of treatment: _____ sessions(s) per _____ week(s).

8. Clinical supervision ..... ☐ yes ☒ no ☐ not required
   Peer review ..... ☐ yes ☒ no
   a. By: _____ Title: _____
   b. Frequency: _____ Duration: _____
   c. Briefly describe how this is documented: _____
   _____
   _____

MDs ONLY:

1. Board eligible:..... ☐ yes ☒ no If yes, when? _____ Specialty(ies)? _____
2. Board certified ..... ☐ yes ☒ no If yes, when? _____ Specialty(ies)? _____
   (Provide proof of eligibility/certification)
3. List hospital(s) in which you have active admitting privileges, and the average number of admissions per month at each:
   _____ #/mo.: _____ _____ #/mo.: _____
   _____ #/mo.: _____ _____ #/mo.: _____
   _____ #/mo.: _____ _____ #/mo.: _____
4. Check the services you provide: ☐ inpatient ☐ medication assessment & management
   ☐ psychiatric assessment ☐ psychotherapy
   ☐ ECT ☐ other/specialty(ies) _____
5. Estimate the percentage of cases you assess that result in hospital admissions per year: _____%
   Out of how many cases total? _____
6. Average length-of-state of your inpatient cases: _____

RISK MANAGEMENT: **(*Must be completed by ALL Applicants*)**

1. ☐ yes ☒ no Have you ever been subject to any lawsuits (civil or malpractice) or been investigated by a professional ethics standards committee or a professional board of inquiry within the past three years?
   ☐ yes ☒ no Under investigation now?

2. ☐ yes ☒ no Have you ever been subject to any inquiry regarding any standards of care or by state regulators?
   ☐ yes ☒ no Under investigation now?

3. ☐ yes ☒ no Have you ever been sanctioned or disciplined by any licensure/certification board, accrediting body, or professional organization?
   ☐ yes ☒ no Under investigation now?

4. ☐ yes ☒ no Have your hospital privileges ever been refused, revoked, suspended or reduced?
   ☐ N/A

5. ☐ yes ☒ no Have you ever been expelled or suspended from, or reprimanded or censured by, Medicare or Medicaid programs?

6. ☐ yes ☒ no Have you ever been investigated, reprimanded or fined by any state agency?
   ☐ yes ☒ no Under investigation now?

7. ☐ yes ☒ no Has your license/certification to practice in any jurisdiction (state or county) ever been revoked, suspended, or subject to probation or any conditions or limitations?
   ☐ yes ☒ no Under investigation now?

8. ☐ yes ☒ no Have you ever been convicted of a felony?

9. ☐ yes ☒ no Are you an owner, partner or investor, or do you have a business interest in a clinical laboratory, diagnostic or testing center, or other involvement with the provision of health services or pharmaceuticals?

10. ☐ yes ☐ no Do you have any physical or mental health condition, treated or untreated, which in any way impairs your ability to practice to the fullest extent of your licensure and qualifications?

11. ☐ yes ☐ no Do you have a chemical dependency/substance abuse problem?

12. ☐ yes ☐ no Has any information pertaining to you ever been reported to the National Practitioner Data Bank?
    ☐ N/A

NOTE: If you have answered "yes" to any of the above questions (1-12), we require that you give further details on a separate sheet of paper. This is to include date of incident, date of results, summary of response/disposition/status, and copies of any order or settlement where applicable.

ATTACH THE FOLLOWING DOCUMENTS:

___ Valid copy of license/certificate showing expiration date

___ Valid copy of insurance

___ Resume/vitae

___ Explanation if "yes" to Questions 1-12 in Risk Management section

MDs ONLY:

In addition to the above documents, also include:

___ Valid copy of DEA registration

___ Proof of residency in psychiatry or board certification(s)

___ ECFMG certificate (for foreign-trained physicians)

OFFICES:
Provide the following information on **ALL** sites/branches from which you provide services. (Attach additional pages if needed and/or submit claims from):

Site/Branch Name: _____

Address: _____

Phone: _____ SS/Tax ID#: _____

Hours: _____

Site/Branch Name: _____

Address: _____

Phone: _____ SS/Tax ID#: _____

Hours: _____

Site/Branch Name: _____

Address: _____

Phone: _____ SS/Tax ID#: _____

Hours: _____

Site/Branch Name: _____

Address: _____

Phone: _____ SS/Tax ID#: _____

Hours: _____

Site/Branch Name: _____

Address: _____

Phone: _____ SS/Tax ID#: _____

Hours: _____

Site/Branch Name: _____

Address: _____

Phone: _____ SS/Tax ID#: _____

Hours: _____

RELEASE OF INFORMATION/AUTHORIZATION

Please read carefully.

In order to more completely evaluate my application for participation,

I CONSENT to the release of any information requested by PBH from any person or entity.

I HEREBY RELEASE from liability for their statement given or information furnished, all persons who submit information concerning my professional qualifications.

I CONSENT to the release of information for the purpose of proper evaluation by PBH of my professional competence, character, ethics and other qualifications.

I RELEASE from liability all representatives of PBH for its acts performed in good faith and without malice in connection with evaluating my application, credentials and qualifications. A photocopy of this permission will serve as the original. I understand that PBH will use this information in confidence solely in conjunction with my application to become a participating provider with PBH.

I UNDERSTAND that subject to proper confidentiality restrictions and authorizations, my office patient records will be subject to inspection by PBH for peer and utilization review purposes.

I HEREBY CERTIFY that the above information is accurate and complete. I understand that any information entered into this application which subsequently is found to be false could result in termination of my contract with PBH.

_____ Date: _____
Signature of Applicant

_____
Printed or Typed Name of Applicant

ADDITIONAL AGREEMENT

A. I understand that the completion of the application is one element of the credentialing process which may also include, without limitation, interviews with PBH, and examination of my experience in providing cost-effective, quality care in the managed care setting and a review of my utilization and quality improvement data.

B. I acknowledge that submission of this Application to PBH in no way entitles me to participation as a Provider and that acceptance of the Application is at the sole discretion of PBH.

C. I understand that final acceptance of my Application is contingent upon my execution of the PBH Provider Agreement.

D. I understand that re-credentialing will occur on a periodic basis in accordance with the PBH rules. I agree to comply with the re-credentialing rules.

E. I agree to promptly notify PBH of any changes in any items recorded in this application, including any changes in my health status which could affect my ability to practice.