TennCare 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: uhccp_bhnetwork@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	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-hour Ob)	☐	☐	☐	☐
ECT	☐ Inpatient		☐ Outpatient	

Substance Use Disorder/Chemical Dependency	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 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	Case Management CCFT, CTT	*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):**													

***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 ACCESSIBILTY

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

ORGANIZATIONAL PROVIDER CONTACT INFORMATION

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

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

FACILITY TYPE INFORMATION

Identify what best describes your organization:

MH	SUD	
☐	☐	Freestanding Day Treatment
☐	☐	Freestanding IOP
☐	☐	General Acute Care Hospital
☐	☐	Free standing Psychiatric Hospital
☐	☐	Residential Treatment Center
☐	☐	Ambulatory Detox (Drug)

MH	SUD	
☐	☐	Ambulatory Detox (Alcohol)
☐	☐	General Acute Hospital with Detox
☐	☐	Psychiatric Residential Facility
☐	☐	Community Mental Health Center
☐	☐	Home Health Care Agency
☐	☐	Facility Opioid Treatment Center

MH	SUD	
☐	☐	Rural Health Clinic
☐	☐	Outpatient Detox Center
☐	☐	SUD Recovery Home
☐	☐	SUD Rehabilitation Facility
☐	☐	SUD Residential Facility
☐	☐	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

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 (Must meet TN state program requirements) 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.*	☐	☐		