# Board-certified behavior analyst/agency network participation request form

**Please read carefully:**

- In order to be considered for network participation, you must fully complete this form. Incomplete forms will delay the response.
- If accepted to formally apply to join the network, UnitedHealthcare Community Plan will provide you with access to the standard credentialing application for the state of Washington

## Email completed application to: WAABACaid@uhc.com

**PROVIDER INFORMATION:**

❑ Individual Board-Certified Behavior Analysts (BCBA) provider in private practice

❑ Agency Provider (indicate total staff numbers within the agency):

Licensed behavioral clinicians: MD _____ PhD _____ MSW _____ RN _____

BCBA Licensed by state? _____ Supervisory designation by BCBA? _____

Board-Certified Assistant Behavior Analysts (BCaBA) _____ Licensed by state? _____

Paraprofessionals/tutors _____ Registered Behavior Technicians®/nationally certified? _____

**Provider name:** _____

Name of practice (dba): _____

Practice address: _____

City_____State_____ ZIP_____

Please indicate if treatment is provided at your private residence. ❑ Yes ❑ No

Phone:_____ Fax:_____ Email: _____

Correspondence address: _____
(Credentialing/recredentialing) (P.O. Box address is not acceptable)

City_____State_____ ZIP_____

Contact name (if other than yourself): _____

Phone:_____ Fax:_____ Email: _____

Remittance address: _____

City_____State_____ ZIP_____

**Agency service area (counties)** _____

How long has your agency been established? _____ years How long providing ABA/IBT svcs?_____

Does your agency utilize televideo technology for supervision or other activities? If yes, please explain:

_____

List the types of intensive behavior approaches your agency utilizes:

_____

List all languages (including sign language) in which you are able to conduct treatment:

_____

**Optional –** Clinician's own ethnicity (data utilized to meet member referral requests):

❑ African American ❑ Alaska Native ❑ Native American Indian ❑ Asian

❑ Caucasian ❑ Hispanic ❑ Native Hawaiian or Pacific Islander ❑ Other



UnitedHealthcare® Community Plan

**PROVIDER IDENTIFICATION INFORMATION:** (If Agency Provider, please complete information for one BCBA on staff)

Tax ID number (TIN)** _____

ABA/IBT National Accreditation number and expiration date _____

Behavior Analyst Board Certification number(s)and expiration date _____

Behavior Analysts license number(s) and expiration date(s) _____

Additional state certification type and number (if applicable) _____

National provider identifier (NPI) number _____

Social Security number _____

CAQH number _____

Date of birth _____

Name of liability insurance carrier/policy number _____

Liability insurance coverage amounts per occurrence/aggregate _____

Liability insurance effective date/term date _____

**If you have more than one TIN/group affiliation, please list additional affiliations

_____ _____

Name of group/practice TIN

**ABA specialty requirements:**

**Individual BCBA –**

- BCBA with active certification from the national Behavior Analyst Certification Board (BACB)

***and***

- State licensure in those states that license behavior analysts
- State certification in those states that certify behavior analysts
- Compliance with all state/autism mandate requirements, as applicable to behavior analysts
- A minimum of 6 months of supervised experience or training in the treatment of applied behavior analysis/intensive behavior therapies
- Minimum professional liability coverage of $1 million per occurrence/$1 million aggregate

**Agency Provider –**

- BCBAs must meet standards above and hold supervisory certification from the national BACB if in supervisory role
- Licensed clinicians must have appropriate state licensure and 6 months of supervised experience or training in the treatment of applied behavior analysis/intensive behavior therapies
- Compliance with all state/autism mandate requirements as applicable to behavior analysts/ABA practices
- BCaBAs must have active certification from the national BACB and appropriate state licensure in those states that license assistant behavior analysts
- Paraprofessionals must have RBT certification from the national BACB or alternative national board certification, and receive appropriate training and supervision by BCBAs or licensed clinician
- BCBA or licensed clinician on staff providing program oversight
- BCBA or licensed clinician performs skills assessments and provides direct supervision of paraprofessionals in joint sessions with client and family
- $1 million/occurrence and $3 million/aggregate of professional liability and $1 million/$1 million of general liability, if services are provided in a clinic setting
- $1 million/occurrence and $3 million/aggregate of professional liability and $1 million/$1 million of supplemental insurance, if the agency provides ambulatory services only (in the patient's home)

**ABA Specialty Attestation Requirement:**

I have reviewed the ABA Specialty Requirements above that I must meet to be credentialed and contracted as a Board-Certified Behavior Analyst and/or ABA Agency Provider. After reviewing the requirements, I hereby attest that by placing a check next to this specialty, I meet UnitedHealthcare Community Plan requirements for this treatment area.

❑ Solo BCBA with required experience in ABA/IBTs ❑ Agency Provider with required experience in ABA/IBTs

**Areas of Clinical Expertise:**

Please indicate populations served and in which you have ABA/IBT training and experience for the treatment of Autism Spectrum Disorder and the type of program(s) for which you provide services.

**ABA/IBTs for Autism Spectrum Disorder (populations served)**

❑ Preschool (0-5 years) ❑ Children (6-12 years)

❑ Adolescents (13-18 years) ❑ Adults (18-21 years)

**Clinic-based programs**

❑ Full-day; 5 days a week 6 hours a day ❑ Half-day; 5 days a week, 3 hours a day

❑ Intensive Outpatient, 3 days a week, 3 hours a day ❑ Other (please specify)_____

**Non-clinic-based programs**

❑ Home-based (10-40 hours a week) ❑ Community-based (3-6 hours a week)

❑ Other (please specify)_____

**Contracted providers have the following rights:**

- To review information submitted to support their (re)credentialing application
- To correct erroneous information obtained by UnitedHealthcare to evaluate their recredentialing application (not including references, recommendations and other peer-review protected information)
- To submit any corrections, in writing, within 10 days
- The right to obtain information regarding the status of their application

I understand that UnitedHealthcare will require documentation to verify that I meet the criteria outlined under specialty requirements pertaining to the specialty designated above. I will cooperate with a UnitedHealthcare documentation audit, if requested, to verify that I meet the required criteria.

I hereby attest that all of the information above is true and accurate to the best of my knowledge. I understand that any information provided, pursuant to this Network Provider Request Form and Specialty Attestation, that is subsequently found to be untrue and/or incorrect could result in my termination from the UnitedHealthcare Community Plan of Washington network.

**Please note that standard credentialing criteria must be met before specialty designation can be considered. All providers must sign this form. Failure to sign this form may cause a delay in the processing of your initial credentialing file.**

_____ _____

Printed name of applicant/agency signatory designee Date

_____

Signature of applicant/agency signatory designee
(Signature stamps are not accepted)




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