Behavioral Health Facility 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 subject to review and approval by the Credentialing Committee. We collect updated credentialing documents approximately every 36 months. The requested information is required in order to comply with our credentialing standards and continue your participation in the network. Additionally, the information you provide will help ensure the accuracy of claims payment.

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	

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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*			
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.**

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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ACCREDITATION If you do not have accreditation, a site visit will be required.				
		Issue Date	Expiration Date	Not Applicable
The Joint Commission				☐
Commission on Accreditation of Rehabilitation Facilities (CARF)				☐
American Osteopathic Association (AOA)				☐
Council on Accreditation (COA)				☐
Community Health Accreditation Program (CHAP)				☐
Center for Improvement in Healthcare Quality (CIHQ)				☐
American Association for Ambulatory Health Care (AAAHC)				☐
Critical Access Hospitals (CAH)				☐
Healthcare Facilities Accreditation Program (HFAP, through AOA)				☐
National Integrated Accreditation for Healthcare Organizations (NIAHO, through DNV Healthcare)				☐
Accreditation Commissions for Healthcare (ACHC)				☐
Please list other Accreditation held by your organization				

COMMISSION of ACCREDITATION of REHABILITATION FACILITIES (CARF) ASAM LEVEL OF CARE CERTIFICATION(S) (if applicable)		
☐ ASAM Level 3.1 (Adult)	☐ ASAM Level 3.5 (Adult)	☐ ASAM Level 3.7 (Adult)

LICENSURE/CERTIFICATION (UnitedHealthcare participating care providers, only include for the level(s) of care being added to contract)				
	Entity Issuing License or Certification	Type of License or Certificate	License Number	Expiration Date
1.				
2.				
3.				
4.				

Does the organizational provider state licensure/certification include a site visit by the State? ☐ Yes ☐ No

If "Yes", please attach a copy of the audit completed by the State with this application.

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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			

LOCATION ACCESSIBILITIES (please complete all conditions that apply)			
	Days	**Hours**	**Not Applicable**
Standard Business Operating Hours			☐
Evening Hours (any hours after 5 p.m.)			☐
Weekend Hours (Saturday or Sunday)			☐
TDD Capability			☐
Public Transportation Access			☐
Wheelchair/Handicap Accessibility			☐

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)** _____

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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 _____

STAFFING

Please answer the following questions relating to your professional psychiatry staff:

1. Are services by psychiatrists restricted to staff/faculty psychiatrists? ☐ Yes ☐ No
2. Number of board-certified psychiatrists on staff: _____
3. Indicate the number of psychiatrist visits per week by level of care:

	IP Acute	Medically Managed Intensive Inpatient Services ASAM 4	Medically Monitored Intensive Inpatient Services ASAM 3.7 WM	SUD Inpatient ASAM 3.7	Clinically Managed High Intensity Residential Services (SUD Residential) ASAM 3.5	MH Residential	Partial Hospitalization ASAM 2.5	MH PHP	Intensive Outpatient Services ASAM 2.1	MH IOP
Number of visits by MD										
Number required in Facility bylaws or policy										

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PREPARATION CHECKLIST

Please provide the following documents:

- ☐ Current State License(s)/Certificate(s) for all behavioral health services you provide (i.e., psychiatric, substance use disorder, 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 network)
- ☐ 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.
- ☐ W-9 form: If multiple tax ID numbers used, one W-9 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

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		

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Please identify any other behavioral health services that are provided by the facility with rate information:

Service Type	Retail Rate	Discount Rate	Comments

DELIVERY OF CARE

Please answer the following questions relating to your policy and procedures as identified:

1. How often is individual therapy provided? _____
2. How often is family therapy provided? _____
3. What is the patient staff ratio? _____
4. What is the staff position responsible for discharge planning? _____
5. Describe your discharge planning procedures:

   _____
6. What percentage of patients are referred for follow-up care? _____
7. What are your protocols for psych testing?

   _____
8. For the partial hospital and IOP services, does the program serve as a step-down or are patients directly admitted?

   _____

   8.1 Does your Partial Hospital or IOP program align with ASAM, LOCUS, CASII, and/or ECSII, as applicable? ☐ Yes ☐ No
9. What percentage of patients is directly admitted to the partial and IOP programs? _____
10. What components are present in your Substance Use Disorder programs?
    - ☐ No SUD services offered
    - ☐ Education is directed to drug of choice
    - ☐ Relapse prevention is part of program
    - ☐ Program meets Department of Transportation requirements
    - ☐ There are criteria for drug/alcohol urine screens
11. Please identify your Average Length of Stay (ALOS) for each program

ALOS	Mental Health Services	ALOS	Substance Use Disorder Services
	Locked		Medically Managed Intensive Inpatient Services (ASAM 4)
	Acute		Medically Monitored Intensive Inpatient Service (ASAM 3.7 WM)
	Residential		Medically Monitored Intensive Inpatient Svcs. (SUD Inpatient) (ASAM 3.7)
	Partial Hospitalization		Clinically Managed High-Intensity Residential Services (SUD Residential) (ASAM 3.5)
	Intensive Outpatient		Partial Hospitalization (ASAM 2.5)
	Other		Intensive Outpatient (ASAM 2.1)
			Ambulatory Detox/Withdrawal Management Services (ASAM 1 WM)

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12. Are there any programs/departments within the facility managed by external organizations? (i.e., emergency room, specialty programs) ☐ Yes ☐ No

If "Yes", please provide the following:

Facility Dept. or Program	Organization Name	Address	Contact Name	Phone

SERVICE DELIVERY/SPECIALTY SERVICES

1. **If Medically Managed Intensive Inpatient (ASAM 4) is offered at the facility, please identify, with a check mark, the physical location of beds:**

☐ Bed located on a medical floor/unit ☐ Bed located on a behavioral health unit

2. **If Facility offers partial hospitalization and/or Intensive Outpatient programs, please indicate number of hours of treatment per day and how many days per week (please review clinical requirements at UHCprovider.com):**

Full-Day Partial _____ Intensive Outpatient _____

3. **If Facility offers both ASAM 3.5 and ASAM 3.7, is Facility aware of the differences in the clinical requirements between the two levels of care?** ☐ Yes ☐ No

4. **Does Facility offer Medication-Assisted Treatment (MAT) in the following levels of care?**

	Available	Not Available
Medically Monitored Intensive Inpatient Services ASAM 3.7 WM	☐	☐
Medically Monitored Intensive Inpatient Svcs. (SUD Inpatient) ASAM 3.7	☐	☐
Clinically Managed High-Intensity Residential Services (SUD Residential) ASAM 3.5	☐	☐

	Available	Not Available
PHP ASAM 2.5	☐	☐
IOP ASAM 2.1	☐	☐
Ambulatory Detox ASAM 1		

Medications: _____

5. **Please indicate if the facility is able to accommodate the following membership needs in your service area:**

	Available	Not Available	Accommodation Method
Member language needs	☐	☐	
Member handicap needs	☐	☐	

a. Are all locations handicapped accessible? ☐ Yes ☐ No

If "No", please indicate which location(s) would not meet the criteria for handicapped accessibility:

_____

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6. **Identify specialty services offered:**	**Available**	**Not Available**	**Location(s)**	**Comments / Descriptions**
Eating Disorder Treatment – Inpatient	☐	☐		
Electro-convulsive Therapy (ECT) - Inpatient	☐	☐		
Electro-convulsive 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	☐	☐		
MH/SUD Outpatient Clinics in a hospital	☐	☐		
Identify specialty services offered (cont.):	**Available**	**Not Available**	**Location(s)**	**Comments / Descriptions**
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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