UnitedHealthcare Community Plan
Facility/Community Mental Health Center Network Request Form/Credentialing Application Tennessee Medicaid (TennCare)

Is the facility currently in the UnitedHealthcare Commmunity PlanTennCare network? ☐ **Yes** ☐ **No**

Acceptance into the United Healthcare Community Plan (UHCCP) provider network is contingent upon the applicant Facility's/Community Mental Health Center meeting our credentialing standards and subject to review and approval by the UHCCP Credentialing Committee. As a reminder, we consider accurate and up-to-date credentialing documents to be a vital part of maintaining a quality network. The need to keep this information current in our files means that we will approach you to request this documentation throughout the life of the contract between the parties. These requests can be expected approximately every 36 months. We understand that complying with this request can be time consuming, but it is required for your continued participation in our network. The information requested is required in order to comply with UHCCP credentialing standards. Additionally, the information you provide will help ensure the accuracy of claims payment.

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 Identification Number					
Billing/Remit Address					
City, State, Zip					

IDENTIFY LEVELS OF CARE FACILITY/COMMUNITY MENATL HEALTH CENTER DESIRES TO CONTRACT
(UHCCP Participating Providers, only select the Level(s) of Care being added to contract)

Substance Abuse/SUD/Chemical Dependency					Psychiatric/Mental Health				
	Geriatric	Adult	Adolescent	Child		Geriatric	Adult	Adolescent	Child
Inpatient Detox	☐	☐	☐	☐	I/P Locked	☐	☐	☐	☐
IP Rehab	☐	☐	☐	☐	I/P Open	☐	☐	☐	☐
Residential	☐	☐	☐	☐	Residential	☐	☐	☐	☐
Residential Detox	☐	☐	☐	☐	Health Link	☐	☐	☐	☐
					Supportive Community Living	☐	☐	☐	☐
					Supportive Housing	☐	☐	☐	☐

					Enhanced Supportive Housing (Medcially Fragile)	☐	☐	☐	☐
					CCFT	☐	☐	☐	☐
					CTT	☐	☐	☐	☐
					ACT/PACT	☐	☐	☐	☐
					Psychosocial Rehab Individual and/or Group	☐	☐	☐	☐
					Peer Support Indvidual and/or Group	☐	☐	☐	☐
					Illness Management Recovery Individual and/or Group	☐	☐	☐	☐
					Supported Employment	☐	☐	☐	☐
Partial Hospitalization.	☐	☐	☐	☐	Partial Hospitalization	☐	☐	☐	☐
SA IOP	☐	☐	☐	☐	MH IOP	☐	☐	☐	☐
Ambulatory Detox (Drug or Alcohol)	☐	☐	☐	☐	Crisis Services (i.e. stabilization, 23 hour Ob)	☐	☐	☐	☐
Medication Assisted Trmt. (MAT) Must meet State Program Description	☐ Buprenorphine				ECT	☐ Inpatient	☐ Outpatient		
Other					Other				

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IDENTIFY PRACTICE LOCATION(S) ONLY FOR ABOVE CHECKED LEVEL(S) OF CARE

Facility/CMHC Location(s)	Age Category/ Population	Mental Health						Substance Abuse						
		Acute Inpatient	Residential	Partial Hospitalization	Intensive Outpatient	Case Management-CCFT,CTT	*Other ____	Inpatient Detox	Inpatient Rehab	Residential	Residential Detoxification	Partial Hospitalization	Intensive Outpatient	*Other ____
Location #1														
	Adult	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	Geri	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	Adol	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Admission	Child	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Phone:		**# of IP Beds (MH):**						**# of IP Beds (SA):**						
Secure Fax:		**# of Medicare Acute IP Beds (MH):**												
Location #2														
	Adult	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	Geri	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	Adol	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Admission	Child	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Phone:		**# of IP Beds (MH):**						**# of IP Beds (SA):**						
Secure Fax:		**# of Medicare Acute IP Beds (MH):**												
Location #3														
	Adult	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	Geri	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	Adol	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Admission	Child	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Phone:		**# of IP Beds (MH):**						**# of IP Beds (SA):**						
Secure Fax:		**# of Medicare Acute IP Beds (MH):**												
Location #4														
	Adult	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	Geri	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	Adol	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Admission	Child	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Phone:		**# of IP Beds (MH):**						**# of IP Beds (SA):**						
Secure Fax:		**# of Medicare Acute IP Beds (MH):**												
Location #5														
	Adult	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	Geri	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	Adol	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Admission	Child	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Phone:		**# of IP Beds (MH):**						**# of IP Beds (SA):**						
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.**

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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			

ACCREDITATION			
	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)			☐
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			☐
			☐

LICENSURE / CERTIFICATION [Optum Participating 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/ NPI / KePRO

	Number	Issue Date	Expiration Date	Not Applicable
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			
National Provider Identifier (NPI)	Primary			☐
	Secondary			

GENERAL / PROFESSIONAL LIABILITY

Please attach current certificates for two types of liability insurance information. Optum insurance requirements are as follows:

For facilities/programs **with** an acute inpatient component:

Professional/general liability	$5,000,000/$5,000,000 minimum coverage

For facilities/programs **without** an acute inpatient component:

Professional liability	$1,000,000/$3,000,000 minimum coverage
Comprehensive general liability	$1,000,000/$3,000,000 minimum coverage

Professional Liability Limits: _____ **General Liability Limits:** _____

If you are self-insured, we require the portion of the facility's independently audited financial statement which shows retention of the required amounts stated above.

LEGAL STATUS

Has the Organizational Provider or any party owning or controlling 5% or more of your company have knowledge of or been subject to disciplinary action, criminal/ethical investigations or convictions, such as but not limited to revocation, suspension or restriction of its license; Medicare/Medicaid provider status; certification or accreditation status (i.e., The Joint Commission, P.R.O., CARF, COA, AOA, etc…); bankruptcy, insolvency or assignment of creditor proceedings?

☐ Yes * ☐ No

** If yes to the above, please attach a brief explanation for each incident.*

LOCATION ACCESSIBILITIES (please complete all conditions that apply)

	Days	Hours	Not Applicable
Standard business operating hours			☐
Evening Hours (any hours after 5pm)			☐
Weekend Hours (Saturday or Sunday)			☐

TDD Capability			☐
Public Transportation Access			☐
Wheelchair 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 facility's applicable licensure(s) is current and free of sanction or limitation. I understand that facility is responsible for adherence to UnitedHealthcare Community Plan credentialing plan, clinical guidelines, and other processes.. 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 http://www.uhccommunityplan.com/health-professionals/tn.html

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 or Medicaid certification letter with Medicare number **(REQUIRED** if applying for participation in Medicaid or Medicare networks)
- ☐ Program Description-including any specialty program descriptions and hours per day/ days per week
- ☐ 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.

Other Documents (ONLY NEEDED FOR NEW FACILITY APPLICANTS):

- ☐ W9 form: If multiple tax ID numbers used, one W9 must be submitted for each
- ☐ 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,

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

MANAGED CARE PARTICIPATION

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List the names of any managed care companies with whom you currently contract (including Optum):

1. _____ How long? _____
2. _____ How long? _____
3. _____ How long? _____

FACILITY TYPE INFORMATION

Identify what best describes your organization:

MH	SA		MH	SA		MH	SA	
☐	☐	Freestanding Day Treatment	☐	☐	General Acute Hospital with Detox	☐	☐	Outpatient Detox Center
☐	☐	Freestanding IOP	☐	☐	Psychiatric Residential Facility	☐	☐	SA Recovery Home
☐	☐	General Acute Care Hospital	☐	☐	Community Mental Health Center	☐	☐	SA Rehabilitation Facility
☐	☐	Free standing Psychiatric Hospital	☐	☐	Home Health Care Agency	☐	☐	SA Residential Facility
☐	☐	Residential Treatment Center	☐	☐	Facility Opioid Treatment Center			
☐	☐	Ambulatory Detox (Drug)						
☐	☐	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	IP Detox	SA Inpatient Rehab	Residential	Partial	IOP
Number of visits by MD						
Number required in Facility bylaws or policy						

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 Abuse/Chemical Dependency		
Level of Care	**Retail**	**Discount**
IP Detox		
Inpatient Rehab		
Residential		
Full day Partial		
Intensive OP		

Please identify any other services that are provided by the facility/Community Mental Health Center with rate information:

Service Type	Retail Rate	Discount Rate	Comments

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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 meet the level of care guidelines
   10. as outlined at http://www.uhccommunityplan.com/health-professionals/tn.h ☐ Yes ☐ No
9. What percentage of patients are directly admitted to the partial and IOP programs? _____
10. What components are present in your Substance Abuse programs?
    - ☐ No SA 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 Abuse Services
	Locked		Detox
	Acute		Inpatient
	Residential		Residential
	Partial Day Hospitalization		Day Treatment
	Intensive Outpatient		Intensive Outpatient

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

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SERVICE DELIVERY / SPECIALTY SERVICES

1. **If detoxification is offered at Facility, please identify, with a check mark, the physical location of detoxification beds:**

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

2. **If Facility offers partial hospitalization programs, please indicate number of hours of treatment her day and how many days per week**

   Full Day Partial _____ Intensive Outpatient _____

3. **Please indicate if Facility/CMHC 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:

_____

4. **Identify speciality services offered:**

Identify speciality 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 UHCCP)	☐	☐		
Chronically Mentally Ill Services (CMI)/Severely Mentally Ill Services (SMI)	☐	☐		
Respite Care Services	☐	☐		
Emergency Room Services (assessment only)	☐	☐		
Twenty-three (23) Hour Crisis Observation	☐	☐		
Crisis Stabilization	☐	☐		
Mobile Crisis (State Assigned County)	☐	☐		
MHSA Outpatient Clinics in a hospital	☐	☐		
Ambulatory Detox - Drug	☐	☐		
Ambulatory Detox - Alcohol	☐	☐		
Medication Assisted Treatment (MAT) - in an Detox, IOP or PHP setting(Must Meet State TN Program Requirements) ☐ Suboxone ☐ Buprenorphine ☐ Naltrexone (i.e. vivitrol)	☐	☐		
Health Link	☐	☐		
Family Support Services	☐	☐		
Other	☐	☐		

ASAM Intensive Inpatient Services *3.7 – Medically Monitored Intensive IP* *4.0 – Medically Managed Intensive IP*	☐	☐		☐ 3.7 ☐ 4.0
Identify services offered (cont):	**Available**	**Not Available**	**Location(s)**	**Comments / Descriptions**
ASAM Residential Services *3.1 – Clinically Managed Low Intensity Res.* *3.3 – Clinically Managed Population – Specific High Intensity Res.* *3.5 – Clinically Managed High Intensity Res.*	☐	☐		☐ 3.1 ☐ 3.3 ☐ 3.5
ASAM Partial Hospitalization Services (PHP) *2.5 – Partial Hospitalization*	☐	☐		
ASAM Intensive Outpatient Services (IOP) *2.1 – Intensive Outpatient*	☐	☐		

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Physician Specialties	Non-Physician Specialties
☐ Child/Adolescent (please specify all ages that you treat): ☐ Infant Mental Health *(0-3 years)* ☐ Preschool *(0-5 years)* ☐ Children *(6-12 years)* ☐ Adolescents *(13-18 years)* ☐ Geriatrics ☐ Buprenorphine – Medication Assisted Treatment (MAT) (submit DEA registration with the DATA 2000 prescribing identification number) ☐ Chemical Dependency / Substance Abuse / Substance Use Disorder (SUD) ☐ Medicaid Office-Based Opioid Treatment Program (OBOT) ☐ Neuropsychological Testing ☐ Substance Abuse Expert (submit Nuclear Regulatory Commission qualification training certificate) ☐ Transcranial Magnetic Stimulation (TMS)	☐ Child/Adolescent (please specify all ages that you treat) – *Psychologiest only*: ☐ Infant Mental Health *(0-3 years)* ☐ Preschool *(0-5 years)* ☐ Children *(6-12 years)* ☐ Adolescents *(13-18 years)* ☐ Certified Employee Assistance Professional (requires CEAP certificate) ☐ Chemical Dependency / Substance Abuse / Substance Use Disorder (SUD) ☐ Critical Incident Stress Debriefing (requires CISD certificate ☐ Employee Assistance Professional ☐ Neuropsychological Testing – *Psychologists only* ☐ Nurses – Prescriptive Privileges (requires ANCC certificate, Prescriptive Authority, DEA certificate and/or State Controlled Substance certificate, based on state requirements) ☐ Peer Bridger/Support Services (requires state peer certification or evidence of current training completion) ☐ Substance Abuse Expert (submit Nuclear Regulatory Commission qualification training certificate) ☐ Substance Abuse Professional (submit Department of Transportation certificate)

I understand that UHCCPmay require documentation to verify that a clinician or clinicians within this Facility/Community Mental Health Cener meet(s) the criteria outlined under Specialty Requirements pertaining to the specialty or specialties I have designated above. The Facility/Community Mental Health Center will cooperate with an UHCCP documentation audit, if requested, to verify that a clinician or clinicians meet(s) 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 attestation that is subsequently found to be untrue and/or incorrect could result in termination from the UHCCPnetwork.

By checking the box below, I am indicating that no clinicians in this Facility/Community Mental Health Center meet the above criteria.

☐ **No Specialties**

Please note that standard credentialing criteria must be met before specialty designation can be considered. An Authorized Agency Representative must sign this form whether any specialty designations are being requested or not. Failure to sign this form may cause a delay in the processing of the Facility/ Community Mental Health Center credentialing file.

Printed Name of Authorized Facility/CMHC Representative

Signature of Authorized Facility/CMHC Representative
(Signature stamps not accepted)

Date _____

UHCCP INTERNAL USE ONLY

FACILITY: _____ TIN: _____ Facets # (if applicable): _____

NETWORK MANAGER/ASSOCIATE

Name: _____ Date Received: _____ Date Reviewed: _____

Networks (check all that apply): ☐ UBH Commercial ☐ Medicare ☐ Medicaid ☐ TriCare ☐ Other _____

# of Covered Lives: _____ Current Network (# of PAR facilities offering same level(s) of care: _____

Network Needs (based on GeoAccess Standards): _____

If network need is determined, Network Manager verified levels of care with facility (**including UHCCP Level of Care Guidelines**).

Date: _____

Confirmed facility has reviewed Provider Manual, Iclaims and clinical guidelines: ☐ Yes ☐ No

PROVIDER SERVICES GOVERNANCE COMMITTEE OUTCOME

Reviewed by Provider Services Governance Committee : Date: _____

☐ APPROVED (Rationale): _____

☐ DENIED (Rationale): _____

Clinical Operation Representative Signature / Title: _____ Date: _____

Network Manager Signature: _____ Date: _____

Outcome Communicated to Facility by Network Manager (if approved, TN educated facility on next steps in process): Date:

CREDENTIALING CHECKLIST
(Only if approved)

Sent to Facility Credentialing Team: Date: _____ Application Sent Via: ☐ ePUF ☐ Email ☐ FORCE

CMS Disclosure Form Attached (required for all State Medicaid providers): ☐ Yes ☐ No/Not Applicable

Site audit request form completed (if applicable): ☐ Yes ☐ No/Not Applicable

Exception Form needed: ☐ Yes ☐ No/Not Applicable

If Yes, Reason for Exception: _____

Additional Comments: _____