Companion
BENEFIT ALTERNATIVES

BEHAVIORAL HEALTH
PROVIDER CREDENTIALING APPLICATION

APPLICATION CHECKLIST:

[ ] Completed application.
[ ] If this is a new office location, completed W9 form or appropriate IRS documentation *(Letter 147C, CP 575 E or tax coupon 8109-C).*
[ ] A signed network agreement for each network you wish to apply.
- Companion Benefit Alternative (CBA) Professional Agreement
- CBA Health Insurance Exchange Addendum
- BlueChoice® HealthPlan Medicaid MCO Agreement

[ ] Copy of state license.
[ ] Copy of Drug Enforcement Administration (DEA) license (if applicable).
[ ] Copy of board certification (if applicable).
[ ] Copy of protocol (advanced practice registered nurses).
[ ] Proof of current malpractice coverage.*
[ ] Completed disclosure of ownership and control interest statement (required for Medicaid MCO network).

*Coverage limits vary: Medical Doctors = JUA/PCF[1] or $1,000,000/$3,000,000
All others = $1,000,000/$1,000,000

Our health plan partners no longer use paper remittances. This includes paper remittance advices and paper checks. You will receive payments and remittance advices electronically. If your group or practice is not currently enrolled in the Electronic Funds Transfer (EFT) program, be sure to complete both the Terms and Conditions for Electronic Payment and the Electronic Funds Transfer Enrollment Form and return them with your application.

CBA is a separate company that provides behavioral health benefits on behalf of BlueChoice HealthPlan and BlueCross® BlueShield® of South Carolina. BlueCross BlueShield of South Carolina and BlueChoice HealthPlan are independent licensees of the Blue Cross and Blue Shield Association.

Please enclose all information and allow at least 30 days for processing before checking on the application status. We cannot process applications until we receive all information. Retain a copy of all application materials for your records.

RETURN APPLICATION TO:
Companion Benefit Alternatives, Inc.
ATTN: Provider Network Coordinator AX-315
P.O. Box 100185
Columbia, SC 29202
Fax Number: 803-714-6456

[1] JUA = Joint Underwriting Association; PCF = Patient Compensation Fund

A. Personal Profile *(Please print or type.)*

Full Name:	**Date of Birth:**	**License:** [ ] MD/DO [ ] Psychologist [ ] APRN [ ] LPC [ ] LMFT [ ] LISW-CP [ ] Physician Assistant

Social Security Number (SSN):	**Individual National Provider Identifier (NPI):**	**Medicaid #:**

Ethnicity : (optional) [ ] African American [ ] Asian Indian [ ] Native American [ ] Pacific Asian [ ] White, non-Hispanic [ ] Other _____	**Gender:** [ ] Male [ ] Female

B. Office Information

1. Primary Office Address		**2. Additional Office Address** *(Please attach another page if you have additional locations.)*	
Group/Practice Name:		Group/Practice Name:	
*Tax ID # (TIN):	TIN Type: [ ] SSN [ ] Employer ID Number (EIN)	*TIN:	TIN Type: [ ] SSN [ ] EIN
Group NPI:		Group NPI:	
Physical Address:		Physical Address:	
Mailing Address:		Mailing Address:	
Billing/Remit Address:		Billing/Remit Address:	
Billing Office Phone:		Billing Office Phone:	
Email Address:		Email Address:	
URL:		URL:	
Appointment Phone:		Appointment Phone:	
Fax:		Fax:	
Contact Name: Phone:		Contact Name: Phone:	
Emergency Phone:		Emergency Phone:	
County:		County:	
Make Checks Payable to:		**Make Checks Payable to:**	

Do you currently practice with any other group or agency? [ ] Yes [ ] No
Will the affiliation(s) with this group or agency remain active? [ ] Yes [ ] No

***Complete a separate W9 form for each TIN.*

Five-Year Work History: ***(DO NOT USE a curriculum vitae or résumé in lieu of completing this section.)***

	Name of Previous/Current Employer(s) *(List the most current first. Include all periods of self-employment.)*	**Date of Employment** **(MM/DD/YY – MM/DD/YY)**
1.		
2.		
3.		
4.		
5.		

Please provide an explanation for any gaps in employment:

C. Office Profile

1. Practice Type (check only one):
   [ ] Solo Practice
   [ ] Group Practice
   [ ] Other: _____

2. Practice Office Hours: [ ] Full Time [ ] Part Time
   Monday _____ to _____
   Tuesday _____ to _____
   Wednesday _____ to _____
   Thursday _____ to _____
   Friday _____ to _____
   Other _____

3. Please list any language(s) other than English you speak: _____

4. Please list any language(s) other than English the clinical or office staff speaks: _____

5. Do you know sign language? [ ] Yes [ ] No TDD Phone #: _____

6. Are you accepting Medicaid patients? [ ] Yes [ ] No

7. Methods to provide emergency coverage 24/7 (check all that apply):

   [ ] Live answering service
   [ ] Cell phone number is available to patients
   [ ] Pager number is available to patients
   [ ] Back-up clinician

8. Is your office accessible to the physically challenged? [ ] Yes [ ] No
   If no, what plan(s) have you made to relocate activities to a maximally accessible location? Please check one of these:
   [ ] Another office in my group is accessible and I will use this.
   [ ] Another location in my building is accessible and I will use this.
   [ ] I will use an office at another location. Describe: _____

New Patient Accessibility

9. Are you currently accepting new patients? [ ] Yes [ ] No

10. Are you occasionally available to see new patients the same day as the referrals? [ ] Yes [ ] No

11. Are you able to schedule an initial appointment within 10 working days of a call? [ ] Yes [ ] No
    If not, what is the average waiting time for initial appointments?
    [ ] 11-20 working days [ ] 21-30 working days [ ] More than 30 working days

Access Standard for Current Patients

12. For non-life-threatening situations that require face-to-face re-evaluation within six hours (e.g., the patient has a significant change in behavior resulting in the patient being unable to perform many day-to-day duties involving work, school, caring for family or taking care of basic needs, such as hygiene) (check all that apply):

    [ ] Telephone
    [ ] Face-to-face
    [ ] Back-up licensed clinician

13. For urgent situations that require face-to-face re-evaluation within 48 hours (e.g., the patient has a significant change in behavior resulting in the patient being unable to perform some day-to-day duties involving work, school, caring for family or taking care of basic needs, such as hygiene) (check all that apply):

    [ ] Telephone
    [ ] Face-to-face
    [ ] Back-up licensed clinician

14. For routine office visits (e.g., medication refill or supportive therapy), how soon can you see a current patient?

    [ ] Within 10 working days (two weeks)
    [ ] Other (please specify): _____

D. Clinical Profile – MDs/DOs Only

This Section Is for Physicians Only.

1. Federal DEA #: _____ State Equivalent (where applicable): _____

2. Board Certified? [ ] Yes [ ] No Board Eligible? [ ] Yes [ ] No

Please list all board certifications and specialty certifications:

Area of Certification: _____

Date of Certification: _____

Date of Re-Certification: _____

Area of Certification: _____

Date of Certification: _____

Date of Re-Certification: _____

Area of Certification: _____

Date of Certification: _____

Date of Re-Certification:_____

PLEASE NOTE:

M.D.s must have board certification or get it within three years of residency and have board eligibility for us to consider you for our panel.

3. List the hospitals where you have privileges.

Primary Privileges:	Other Privileges:	Other Privileges:
Address:	Address:	Address:
Phone:	Phone:	Phone:

4. Are your hospital privileges active and in good standing? [ ] Yes [ ] No

5. If you do not have active admitting privileges, please verify how you handle acute care.

_____

_____

_____

E. Professional References

All providers please complete this section.

Name:	Name:
Address:	Address:
Phone:	Phone:
Web Address:	Web Address:

F. License/Insurance Profile

1. Please indicate your licensure information.

Primary Licensure [select one PRIMARY code]	
[ ] Psychiatrist [ ] Adult [ ] Child and Adolescent [ ] Geriatric **[ ]** Psychologist **[ ]** Social Worker **[ ]** Marriage and Family Counselor **[ ]** Licensed Professional/Mental Health Counselor **[ ]** Psychiatric Clinical Nurse Specialist (ANCC Certification) **[ ]** Psychiatric Nurse Practitioner **[ ]** Other: _____	License #: _____ Issue Date: _____ Exp. Date: _____ State: _____ **NOTE**: Please attach copies of state license. Also attach copies of board certification and DEA licensure as applicable. Please list any additional licensure information:

2. Are you eligible to receive third-party reimbursement? [ ] Yes [ ] No

3. Please attach a copy of your most recent malpractice insurance. Required malpractice history information includes the name(s) and address(es) of all malpractice companies with whom you or your employer contracted for coverage.

Carrier's Name/Address	Policy Number	Effective Date	Expiration Date	Amount of Coverage

G. Provider Areas of Expertise

1. Please indicate your top **10** areas of expertise. We will list these specialties with your name in our provider directory.

[ ]	ABA	**Behavioral Therapy for Autism Disorders**
[ ]	ABU	**Abuse, Assault and Trauma (PTSD)**
[ ]	ADD	**Attention Deficit Disorder (ADD/ADHD)**
[ ]	ADP	**Adoption**
[ ]	AP	**Anxiety and Panic Disorders**
[ ]	ASD	**Autism Spectrum Disorders (ASD/PPD/Asperger)**
[ ]	BAR	**Bariatric Assessment**
[ ]	BEH	**Behavior Modification**
[ ]	BPD	**Bipolar Disorders/Manic Depressive Illness**
[ ]	BSF	**Brief Solution Focused**
[ ]	CBT	**Cognitive Behavioral Therapy (CBT)**
[ ]	CD	**Chemical Dependency/Chemical Dependency Assessment**
[ ]	CHR	**Christian Counseling**
[ ]	DBT	**Dialectical Behavioral Therapy (DBT)**
[ ]	DEP	**Depression**
[ ]	DIV	**Divorce/Blended Family Issues**
[ ]	EAT	**Eating Disorders**
[ ]	ECT	**Electroconvulsive Therapy (ECT)**
[ ]	ELI	**End-of-Life Issues**
[ ]	ETH	**Cultural/Ethnic Issues**
[ ]	FAM	**Family Therapy**
[ ]	GAM	**Compulsive Gambling**
[ ]	GER	**Geriatrics**
[ ]	GLB	**Gay/Lesbian/Bisexual Issues**
[ ]	GRP	**Group Therapy**
[ ]	HIV	**HIV/AIDS Related Issues**
[ ]	INF	**Infertility**
[ ]	MED	**Medication Management**
[ ]	MEN	**Men's Issues**
[ ]	NEU	**Neuropsychological Testing**
[ ]	OCD	**Obsessive Compulsive Disorders**
[ ]	PER	**Personality Disorders**
[ ]	PM	**Pain Management**
[ ]	PN	**Prenatal Issues**
[ ]	PP	**Postpartum Issues**
[ ]	SCH	**Schizophrenic Disorders**
[ ]	SEX	**Sexual Disorders**
[ ]	TRN	**Transgender Issues**
[ ]	TST	**Psychological Testing**
[ ]	WOM	**Women's Issues**

2. Please list specialized training or experience in any of these areas or any additional professional certifications. (Do not use abbreviations.)

_____

_____

_____

3. Please check the age group(s) to which you provide services:

[ ] Child (0-12 years) [ ] Adult (18-65)
[ ] Adolescent (13-17 years) [ ] Geriatric (65+)

H. Educational Profile

All providers please complete this section.

Undergraduate School: _____ Month/Year of Graduation: _____

Street Address: _____ Major: _____ Degree: _____

City: _____ State: _____ ZIP Code: _____

Graduate School: _____ Month/Year of Graduation: _____

Street Address: _____ Major: _____ Degree: _____

City: _____ State: _____ ZIP Code: _____

Medical School: _____ Month/Year of Graduation: _____

Street Address: _____ Specialty: _____

City: _____ State: _____ ZIP Code: _____

Internship: _____ Month/Year of Completion: _____

Street Address: _____ Specialty: _____

City: _____ State: _____ ZIP Code: _____

Residency: _____ Month/Year of Completion: _____

Street Address: _____ Specialty: _____

City: _____ State: _____ ZIP Code: _____

Fellowship: _____ Month/Year of Completion: _____

Street Address: _____ Specialty: _____

City: _____ State: _____ ZIP Code: _____

I. Attestation

If you answer yes to any of these questions, please attach a written detailed explanation and any relevant documentation.

1.	Do you have any pending misdemeanor or felony charges?	[ ] Yes	[ ] No
2.	Have you ever been convicted of a felony?	[ ] Yes	[ ] No
3.	Has your license to practice in any jurisdiction ever been voluntarily or involuntarily denied, restricted, suspended, challenged, revoked, conditioned or otherwise limited?	[ ] Yes	[ ] No
4.	In the past five years, and up to and including the present, have you had any ongoing physical or mental impairment or condition that would make you unable, with or without reasonable accommodation, to perform the essential functions of a provider in your area of practice, or unable to perform those essential functions without a direct threat to the health and safety of others?	[ ] Yes	[ ] No
5.	Considering the essential functions of a provider in your area of practice, in the past five years, and up to and including the present, have you suffered from any communicable health conditions that could pose a significant health and safety risk to your patients?	[ ] Yes	[ ] No
6.	Have you ever been publicly reprimanded or disciplined by a professional licensing agency or board, or are you aware of any pending investigations or complaints?	[ ] Yes	[ ] No
7.	Has your DEA certification or state-controlled drug permit ever been restricted, revoked, voluntarily relinquished or otherwise limited?	[ ] Yes	[ ] No
8.	Have any of your privileges or memberships at any hospital or institution ever been denied, suspended, reduced, revoked, voluntarily relinquished or otherwise limited?	[ ] Yes	[ ] No
9.	Has your participation in Medicare, Medicaid or any other government program ever been limited or curtailed, or have you voluntarily excluded yourself from any of these programs?	[ ] Yes	[ ] No
10.	Has your participation in an insurance company network ever been limited or terminated?	[ ] Yes	[ ] No
11.	Have you had a history of chemical dependency or substance abuse that might affect your ability to competently and safely perform the essential functions of a provider in your area of practice?	[ ] Yes	[ ] No
12.	Have you had or do you have any mental or physical condition, or do you take any medications that might affect your ability to competently and safely perform the essential functions of a provider in your area of practice?	[ ] Yes	[ ] No
13.	Has any malpractice carrier ever made an out-of-court settlement or paid a judgment of a medical malpractice claim on your behalf, or have you ever been named in a malpractice suit that was settled, active or dismissed?	[ ] Yes	[ ] No
14.	Has your professional liability insurer ever placed conditions or restrictions on your coverage or ability to get coverage?	[ ] Yes	[ ] No
15.	Are you aware of any potential malpractice suits that may be filed against you?	[ ] Yes	[ ] No

J. Consent

I understand that:

A. It is my responsibility to promptly advise CBA in writing within 30 days of any changes or additions to the information contained in this application.

B. This is an application only and my submission of this application does not automatically result in participation with CBA.

C. The CBA Professional Agreement is deemed effective on the date signed by the director of CBA.

Notice: *We will query the National Provider Data Bank if you apply. If we reject your application for reasons relating to professional conduct or professional competence, including misrepresenting, misstating or omitting a relevant fact in connection with your application, we may report the rejection to the National Provider Data Bank.*

I, the undersigned, hereby attest that the information given in or attached to this application is accurate, complete and true; and fairly represents the current level of my training, experience, capability and competence to practice at the level requested. I specifically authorize CBA and its authorized representative to consult with any third party who may have information bearing on the subject addressed by this application, and to inspect or obtain any reports, records, recommendations or other documents or disclosures of said third parties that may be material to the questions in this application. I also specifically authorize any such third parties to release said information to CBA and its authorized representatives upon request. I hereby release CBA and its authorized representative and any of such third parties from any liability for any such reports, records, recommendations or other documents or disclosures involving me that are made, requested or received by CBA and/or its authorized representatives to, from or by any such third parties, including otherwise privileged or confidential information, made or given in good faith and relating to the subject matter addressed by this application. I have the right to review information obtained by CBA to evaluate this credentialing application.

In choosing to participate in the CBA Provider Network, the Undersigned represents and warrants the truth and accuracy of the statements made in his/her application, and CBA shall be entitled to rely upon such statements. CBA makes no representation or warranty concerning the truth and/or accuracy of any statements made by the participating Practitioner in his/her application or related materials.

If I am accepted for participation in CBA, I consent to CBA's inspection of my patient records as allowed by law necessary for its peer and utilization review and quality assessment purposes, and agree to be bound by CBA's participation agreement, credentialing plan, policies and procedures.

A photocopy of this authorization shall be deemed equivalent to the original.

Any information you enter into this application that subsequently is found to be false could result in your dismissal from CBA's network.

_____ _____

Applicant ***Date***

You must sign the application in ink. Stamped signatures are not acceptable.

Practitioners have the right to:

1. Review information submitted to support the credentialing application.
2. Correct erroneous information.
3. To be informed of the status of the credentialing application.

To exercise the above rights, please email your inquiries to CBA.Provrep@companiongroup.com.

Form **W-9**
(Rev. August 2013)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

Give Form to the requester. Do not send to the IRS.

Print or type
See Specific Instructions on page 2.

Name (as shown on your income tax return)

Business name/disregarded entity name, if different from above

Check appropriate box for federal tax classification:
☐ Individual/sole proprietor ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=partnership) ▶ _____

☐ Other (see instructions) ▶

Exemptions (see instructions):
Exempt payee code (if any) _____
Exemption from FATCA reporting code (if any) _____

Address (number, street, and apt. or suite no.)

Requester's name and address (optional)

City, state, and ZIP code

List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on the "Name" line to avoid backup withholding. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

Note. If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.

Social security number
☐☐☐ – ☐☐ – ☐☐☐☐

Employer identification number
☐☐ – ☐☐☐☐☐☐☐

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and
3. I am a U.S. citizen or other U.S. person (defined below), and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions on page 3.

Sign Here | **Signature of U.S. person** ▶ | **Date** ▶

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. The IRS has created a page on IRS.gov for information about Form W-9, at *www.irs.gov/w9*. Information about any future developments affecting Form W-9 (such as legislation enacted after we release it) will be posted on that page.

Purpose of Form

A person who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, payments made to you in settlement of payment card and third party network transactions, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify that you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income, and
4. Certify that FATCA code(s) entered on this form (if any) indicating that you are exempt from the FATCA reporting, is correct.

Note. If you are a U.S. person and a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

Definition of a U.S. person. For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States,
- An estate (other than a foreign estate), or
- A domestic trust (as defined in Regulations section 301.7701-7).

Special rules for partnerships. Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax under section 1446 on any foreign partners' share of effectively connected taxable income from such business. Further, in certain cases where a Form W-9 has not been received, the rules under section 1446 require a partnership to presume that a partner is a foreign person, and pay the section 1446 withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid section 1446 withholding on your share of partnership income.