



BEHAVIORAL HEALTH SYSTEM OF CARE PROVIDER APPLICATION

(Please complete entire application)

Provider Name:						
Business Address:						
City:		State:		Zip:		
Phone Number:		Fax:				
EIN:						
Primary Billing Contact:		Title:				
Primary Billing Contact Phone #:		Email:				
Billing Address: (if different from above)		Fax:				
City:		State:		Zip:		
STBH Contact Person:		Title:				
Phone Number:		Email:				

UNDERSTANDING OF SCOPE OF SERVICES

Please provide a brief description of your understanding of services to be delivered as a provider of STBH services:	
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Insurance Panels Accepted: (Please check all that apply)	<input type="checkbox"/> None <input type="checkbox"/> CareFirst _____ <input type="checkbox"/> Medicaid <input type="checkbox"/> Kaiser Mid Atlantic <input type="checkbox"/> Aetna <input type="checkbox"/> Cigna <input type="checkbox"/> Anthem Medicaid <input type="checkbox"/> United Healthcare <input type="checkbox"/> Tricare <input type="checkbox"/> Humana <input type="checkbox"/> INTotal Health <input type="checkbox"/> Anthem <input type="checkbox"/> Anthem HMO <input type="checkbox"/> Anthem PPO <input type="checkbox"/> Anthem Health Keepers <input type="checkbox"/> Anthem Health Keepers + <input type="checkbox"/> Optima <input type="checkbox"/> BCBS <input type="checkbox"/> United Behavioral Health Others: (Please List) _____ _____ _____
Proposed Rate:	\$ _____
After hours and emergency protocols: (Please describe)	

APPLICATION CHECKLIST

(Please attach the following required documentation with your application)

- Insurance Accord Certificate
- W-9
- Copies of clinical license and resume **for each proposed STBH participating therapist**
- Certificate (or comparable documentation) to verify training in CBT, Trauma Informed Care, Crisis)
- Copy of clinical assessment if not able to use STBH clinical assessment (if consideration for approval is requested)
- Copy of invoice

All of the information in this application is accurate and truthful. This application is submitted with the intent to enter into an Agreement for the Purchase of Services as a Provider of Services.

Signature of Authorized Representative/Title

Date

Printed Signature