

**SHORT TERM BEHAVIORAL HEALTH (STBH) SERVICES PROVIDER APPLICATION**

**Part 1 (1 of 2)**

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| **Provider Name:**  |  |  |
| **Business Address:**  |  |  |
| **City:**  |  | **State:**  |  | **Zip:**  |  |
| **Phone Number:**  |  | **Website:**  |  |
| **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:**  |  |

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| **Insurance Panels Accepted:** **(Please check all that apply)**  | ☐ CareFirst ☐ Medicaid ☐ Kaiser Mid Atlantic ☐ Aetna ☐ Cigna ☐ Anthem Medicaid ☐ United Healthcare ☐ Tricare ☐ Humana ☐ INTotal Health ☐ Anthem ☐ Anthem HMO  | ☐ Anthem PPO ☐ Anthem Health Keepers ☐ Anthem Health Keepers + ☐ Optima ☐ BCBS ☐ United Behavioral Health ☐ None☐ Other (please list): |
| **Proposed Hourly Rate (Propose an hourly rate which takes into consideration the public-private nature of this partnership.):** | **$** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
| **After hours and emergency protocols:**  **(Please describe)**  |  |
| **STBH PROVIDER APPLICATION PART 1 CHECKLIST** **(Please check off and be sure to attach all required documentation outlined below.)**  |
| ☐ Insurance Accord Certificate for the Provider ☐ W-9 form for the Provider (tax identification) ☐ Part 2: STBH Clinician Authorization Form(s) - one form MUST be completed for each clinician  |

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

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Signature of Authorized Representative/Title Date

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## Print Name

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