

**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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