CommunityCare™

Provider Participation Criteria

To be presented at our Network Development Committee the following documents must be completed for each individual being considered.

- Participation request form
- Questionnaire form
- Copy of a resume and clinical license
- Sample claim with boxes 25, 31, 32 & 33 filled in (blank 1500 form is in attachment)
- Signed W9

To be considered for provider status with CommunityCare Behavioral Health Services, a provider must meet the following criteria:

- Available for appointments a minimum of 20 hours per week;
- Cannot be employed elsewhere full-time;
- Available for case reviews Monday through Friday between 8 a.m. and 5 p.m.; and
- Available or have provisions for emergent situations with established patients.

Following receipt of the requested information, CommunityCare will review the provider's application and notify provider of decision regarding participation. Providers approved for participation must successfully complete the credentialing process and sign a participation agreement prior to becoming effective in the network.

PARTICIPATION REQUEST FORM

❑ **CommunityCare HMO** ❑ **CommunityCare Life & Health PPO** ❑ **CommunityCare Government Programs**

❑ **Preferred CommunityChoice PPO** ❑ **WorkNet**

PROVIDER NAME _____
First Middle Last Title/Licensure

INDIVIDUAL NPI#_____ **SS# (MUST INCLUDE)**_____ **DATE OF BIRTH**_____

SPECIALTY (1)_____ **(2)** _____

☐PCP ☐Specialist ☐Hospitalist ☐Allied Health ☐Ancillary If PCP, are OB services provided? ☐ Yes ☐ No

Do you participate in Medicare? ☐ **Yes** ☐ **No** **Medicare #** _____

Do you admit your own patients? ☐ **Yes** ☐ **No If no, who admits for you:** _____

ADMITTING HOSPITAL PRIVILEGES: _____

IF PHYSICIAN EXTENDER (PA, ARNP), ARE YOU EMPLOYED BY A COMMUNITYCARE OR PREFERRED COMMUNITYCHOICE CONTRACTED PROVIDER? ☐ **YES** ☐ **NO**

IF YES, NAME OF SUPERVISING PHYSICIAN OR ENTITY _____

PRACTITIONER NAME AS IT APPEARS ON CLAIM FORMS: _____

Tax ID #_____ **Federal Tax ID Owner Name:** _____

GROUP NPI #:_____ **Group Practice Name:** _____

MULTIPLE OFFICE LOCATIONS? ☐ **YES** ☐ **NO (COMPLETE SEPARATE REQUEST FORM FOR EACH LOCATION)**

PRIMARY OFFICE ADDRESS:

_____
Street Address

_____
Office/Suite

_____
City, State, Zip

_____
Office Phone #

_____
Office Fax #

CREDENTIALING CONTACT:
LIST ENTITY NAME IF USING A CREDENTIALING COMPANY

_____
Name

_____
Address

_____
City, State, Zip

_____
Phone #

_____
Fax #

REMITTANCE ADDRESS: ☐ Check if same as above

_____
Street Address

_____
Office/Suite #

_____
City, State, Zip

_____
Phone #

_____
Fax #

PHYSICIANS AND/OR PHYSICIAN EXTENDERS WITHIN GROUP:
PLEASE LIST NEW PROVIDERS ON SEPARATE REQUEST FORM

CommunityCare's representatives are prohibited by the company's Code of Conduct from using their positions to unfairly profit (or assist others to unfairly profit) in any way at CommunityCare's expense. Does any employee, officer, director or other representative of CommunityCare own a financial interest in the Applicant, serve as an employee, officer, director, agent or consultant for the Applicant, or have any other relationship with or to the Applicant that could present a conflict of interest for the representative of CommunityCare? Such other relationships include, but are not limited to, being related by blood or marriage to any of the Applicant's officers, directors, or equity owners. (e.g., shareholders; general or limited partners). **Yes** ☐ **No**☐ If yes, whom?_____

Submit this form **completed in its entirety** along with a **signed W9 and a sample claim form** via fax, email, or mail to:

CommunityCare
Provider Network Administrator
Williams Center Tower II | Two West Second Street, Suite 100 | Tulsa, Oklahoma 74103
Tulsa (Ph) 918-594-5295 Ext. 4033 (Fax) 918-877-9736
Request_to_Contract@ccok.com

Dear Provider:

We appreciate your interest in becoming a CommunityCare/Preferred CommunityChoice Behavioral Health Provider. The following questions are designed to help us appropriately build a useful provider network. Please take time to thoroughly complete the following and return it along with your Curriculum Vitae or resume and a cover letter.

Name:_____

Office Address: _____

City, State, Zip:_____

1) With what ages of patients do you prefer to work (children, elderly, etc.)?

2) What hours are you currently available to see clients? Are these flexible (i.e. evenings, weekends, etc.)?

3) What is your average number of sessions per client?

4) With which Managed Care Organizations have you been or are you currently contracted? (this is voluntary)

5) Are you familiar with or accustomed to checking eligibility and obtaining certifications prior to seeing patients? If so, what types of procedures did you follow?

6) What is the average number of days until a patient's initial appointment? Routine? Urgent? Emergent?

7) Do you currently offer group(s)? If so, what group topics do you cover?

8) What is your office's billing procedures?

9) If you are not a psychiatrist, which psychiatrists do you consult with or refer to?

10) Approximately, when was the last time you consulted a client's PCP or psychiatrist? What was the result of that consultation?

Name: _____

11) What method/approach do you take with your treatment?

12) How would you describe your client population? (Include your most difficult case, your most successful case, as well as your average population.)

13) Complete the following in order for us to review your request for contract consideration:

All Providers (including MD/DO):

Do you participate in Medicare? Y / N If yes, Medicare # _____

License #_____Is your malpractice insurance at least 1ml/1ml? Y / N

Office manager/contact person_____

Office hours:_____

Additional languages: _____

MD/DO only:

Board Certified: Y / N Do you currently have hospital privileges? Y / N With which facilities? _____

Are your privileges unrestricted? Y / N

Thank you for your time and your interest in CommunityCare/Preferred CommunityChoice.

Sincerely,

Provider Network Administrator

**All information given is voluntary and confidential. This request does not guarantee membership in our provider network.

Name: _____

Please check appropriate Areas of Practice

AGE RANGES YOU SEE:

_____All ages (_____to_____)
_____Children only (5 - 11)
_____Adolescents Only (12 - 17)
_____Children through Adults
_____Children & Adolescents
_____Adolescents & Adults
_____Adults & Geriatrics
_____Adults Only (18 - 65)
_____Geriatrics Only (65 +)

AREAS FOR WHICH YOU HAVE SPECIAL TRAINING:

____Biofeedback
____Christian Counseling
____Hypnotherapy
____Pain Management
____Play Therapy
____Neuropsych Testing

____Sexual Dysfunction
____Sign Language
____Sleep Hygiene Therapy
____Spanish Language

SPECIAL POPULATIONS FOR WHICH YOU PROVIDE SERVICES:

____Autism Spectrum Disorders
____Children under age 5
____Developmentally Disabled
____Geriatrics (Dementia)
____HIV Positive
____LGBT
____Traumatic Brain Injury
____Veterans

PRACTICE AREAS – If **ALL** areas under a **bolded heading apply,** please select the heading only. Otherwise, select each area that applies.

_____Abuse or Neglect
- ____Child Abuse
- ____Domestic Violence
- ____Rape
- ____Sexual Abuse/Incest
- ____Sex Offender

_____Addictions
- ____Chemical Dependency – Adolescents
- ____Chemical Dependency – Adults
- ____Dual Diagnosis
- ____Gambling Addiction
- ____Sex Addiction

____Behavior Problems
- ____ADD/ADHD
- ____Obsessive Compulsive D/O

____Bipolar

____Dissociative Disorders/PTSD

____Eating Disorders

_____Panic/Anxiety

_____Personality Disorders

_____Schizophrenia and Psychotic Disorders

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SAMPLE CLAIM FORM

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA — PICA

1. MEDICARE (Medicare#) | MEDICAID (Medicaid#) | TRICARE (ID#/DoD#) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (ID#) | FECA BLK LUNG (ID#) | OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY — SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED — Self | Spouse | Child | Other

7. INSURED'S ADDRESS (No., Street)

CITY — STATE

8. RESERVED FOR NUCC USE

CITY — STATE

ZIP CODE — TELEPHONE (Include Area Code) ( )

ZIP CODE — TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) — YES | NO

a. INSURED'S DATE OF BIRTH MM DD YY — SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? — YES | NO — PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? — YES | NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? — YES | NO — If yes, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY — QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY — FROM — TO — MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY — FROM — TO — MM DD YY

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? — YES | NO — $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) — ICD Ind.

A. B. C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE — ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1										NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER — SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) — YES | NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)