PHP BEHAVIORAL HEALTH NETWORK

New Behavioral Health Provider Profile Form

If you are interested in contracting with PHP or are currently contracted and would like to add providers to your group or start a new solo practice, please complete this form and email to PHP_BH_Network@providence.org.

PROVIDER PROFILE							
FIRST NAME:		**MIDDLE NAME/INITIAL:**		**LAST NAME:**			
GENDER ORIENTATION:		**DATE OF BIRTH:**					
LICENSE INFORMATION	TYPE:		License Number:				
INDIVIDUAL NPI:		**GROUP NPI:**					
PROVIDER EMAIL ADDRESS: (NOT INCLUDED IN DIRECTORY)							
PRACTICE ASSIGNMENT:	☐ SOLO (1 licensed provider)		☐ GROUP (2+ licensed providers)				
TELEHEALTH	☐ Telehealth Services Offered (office AND virtual visits)	☐ Telehealth Only (virtual visits only)	☐ In-person Services Only				
A PHYSICAL PRACTICE ADDRESS IS REQUIRED TO BE LISTED IN THE DIRECTORY. WOULD YOU LIKE YOUR ADDRESS WITHELD?	☐ By checking this box, I acknowledge that I will be omitted from the PHP directory.						
SOLO PRACTICE OR GROUP NAME:		**NAME ON CHECK**					
PRIMARY PHYSICAL ADDRESS: (FOR DIRECTORY)							
CITY:		**STATE:**		**ZIP CODE:**		**COUNTY:**	
PHONE: (FOR DIRECTORY)		**FAX:**					
MAILING ADDRESS:							
CITY:		**STATE:**		**ZIP CODE:**		**COUNTY:**	
NAME ON TAX ID:		**TAX ID:**					
1099 ADDRESS:							
CITY:		**STATE:**		**ZIP CODE:**		**COUNTY:**	
BILLING/REMIT ADDRESS: (IF DIFFERENT FROM MAILING)							
CITY:		**STATE:**		**ZIP CODE:**		**COUNTY:**	
SECONDARY PHYSICAL ADDRESS:							
CITY:		**STATE:**		**ZIP CODE:**		**COUNTY:**	
LANGUAGE FLUENCIES:		**CULTURAL COMPETENCIES:**					
MEDICARE NUMBER:							

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CREDENTIALING INFORMATION			
CREDENTIALING CONTACT NAME:			
PHONE:		**EMAIL:**	
CONTRACTING INFORMATION			
CONTRACT CONTACT NAME:			
PHONE:		**EMAIL:**	

ARE YOU CURRENTLY PROVIDING SERVICES TO ANY PHP MEMBERS?	☐ YES	☐ NO
IF YES, DO YOU PLAN TO CONTINUE WORKING WITH THESE MEMBERS DURING THE CREDENTIALING/CONTRACTING PROCESS?	☐ YES	☐ NO

ARE YOU AN LPC/LMFT AND INTERESTED IN CONTRACTING FOR MEDICARE?	☐ YES	☐ NO
IF YOU MARKED YES ABOVE, DO YOU CURRENTLY HAVE A MEDICARE NUMBER?	☐ YES	☐ NO

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Instructions: *Please list all providers, their license type, and NPI number assigned that you are looking to credential.*

- *If a CAQH application is completed and/or updated, please list the CAQH # below.*
- *If an OPCA application is complete, you may attach to your submission.*

NAME	LICENSE TYPE	NPI	CAQH# (IF APPLICABLE)	DATE OF BIRTH	GENDER ORIENTATION	CULTURAL COMPETENCY (YES/NO)	LANGUAGE FLUENCIES	MEDICARE NUMBER

NAME	LICENSE TYPE	NPI	CAQH# (IF APPLICABLE)	DATE OF BIRTH	GENDER ORIENTATION	CULTURAL COMPETENCY (YES/NO)	LANGUAGE FLUENCIES