



SVCMC, Inc.



US FAMILY  
HEALTH PLAN

**ANCILLARY MENTAL HEALTH APPLICATION**

**GENERAL INFORMATION**

Ancillary Facility Name:  Network/Health System:

Service Type:

NPI:  CCN:

Service Locations:

Address:

City:  State:  Zip:  County:

Phone:  Fax:  Email:

*Please attach additional service locations separately*

**BILLING INFORMATION – W9**

Corporate/ Pay to Name:  Doing Business As:

Phone #:  TIN:

Billing Address:

City:  State:  Zip:  County:

Billing Contact Name:

Phone #:  Fax:  Email:

*Must include official W9*

**MANAGED CARE CONTACT**

Contact Name:

Phone #:  Email:

**ACCREDITATION (TJC, CARF, ACHC etc., required)**

Accrediting Organization:

Status:  Effective Date:  Expiration Date:

Medicare Certified: Yes ☐ No ☐ TRICARE Authorized Provider: Yes ☐ No ☐

**LICENSURE/OPERATING CERTIFICATE**

*Attach copy of each license/operating certificate:*

Licensure Type:

Licensing State:

License Number:

Expiration Date:

DEA Registration (if applicable):

Expiration Date:

Other certifications/memberships

## SERVICE AREA/SPECIAL CAPACITY

Facility Type (check all that apply):

| <u>Inpatient</u>                                                                          | Yes/ No                                                  | <u>Intensive Outpatient Programs (IOP)</u> | Yes/ No                                                  |
|-------------------------------------------------------------------------------------------|----------------------------------------------------------|--------------------------------------------|----------------------------------------------------------|
| Inpatient Psychiatric Hospitals - Adult                                                   | <input type="checkbox"/> Yes <input type="checkbox"/> No | SUD IOP Adult                              | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Inpatient Psychiatric Hospitals - Adolescent                                              | <input type="checkbox"/> Yes <input type="checkbox"/> No | SUD IOP Adolescent                         | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Inpatient Psychiatric Hospitals - Child 0-12yrs                                           | <input type="checkbox"/> Yes <input type="checkbox"/> No | Mental Health IOP Adult                    | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Inpatient Psychiatric Hospital - Trauma/PTSD                                              | <input type="checkbox"/> Yes <input type="checkbox"/> No | Mental Health IOP Adolescent               | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Inpatient Psychiatric Hospital - ECT                                                      | <input type="checkbox"/> Yes <input type="checkbox"/> No | Mental Health IOP Child                    | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Inpatient Detox - Adult                                                                   | <input type="checkbox"/> Yes <input type="checkbox"/> No | Mental Health Eating Disorder Adult        | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Inpatient Detox - Adolescent                                                              | <input type="checkbox"/> Yes <input type="checkbox"/> No | Mental Health Eating Disorder Adolescent   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Inpatient Eating Disorder - Adult                                                         | <input type="checkbox"/> Yes <input type="checkbox"/> No | Mental Health Eating Disorder Child        | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Inpatient Eating Disorder - Child                                                         | <input type="checkbox"/> Yes <input type="checkbox"/> No |                                            |                                                          |
| Inpatient Eating Disorder - Adolescent                                                    | <input type="checkbox"/> Yes <input type="checkbox"/> No |                                            |                                                          |
| <u>Inpatient/Residential Substance Use Disorder Rehabilitation Facilities (SUDRF)</u>     |                                                          | <u>Opioid Treatment Program (OTP)</u>      |                                                          |
| SUDRF - Adult                                                                             | <input type="checkbox"/> Yes <input type="checkbox"/> No | Opioid treatment programs                  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| SUDRF - Child                                                                             | <input type="checkbox"/> Yes <input type="checkbox"/> No |                                            |                                                          |
| SUDRF - Adolescent                                                                        | <input type="checkbox"/> Yes <input type="checkbox"/> No | <u>Programs</u>                            |                                                          |
|                                                                                           |                                                          | Eating Disorder Programs                   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <u>Residential Treatment Center</u>                                                       |                                                          |                                            |                                                          |
| Adolescent 13-18yrs                                                                       | <input type="checkbox"/> Yes <input type="checkbox"/> No |                                            |                                                          |
| Child 0-12yrs                                                                             | <input type="checkbox"/> Yes <input type="checkbox"/> No |                                            |                                                          |
| <u>Psychiatric And Substance Use Disorder (SUD, Partial Hospitalization Program (PHP)</u> |                                                          |                                            |                                                          |
| SUD PHP Adult                                                                             | <input type="checkbox"/> Yes <input type="checkbox"/> No |                                            |                                                          |
| SUD PHP Adolescent                                                                        | <input type="checkbox"/> Yes <input type="checkbox"/> No |                                            |                                                          |
| Mental Health PHP Adult                                                                   | <input type="checkbox"/> Yes <input type="checkbox"/> No |                                            |                                                          |
| Mental Health PHP Adolescent                                                              | <input type="checkbox"/> Yes <input type="checkbox"/> No |                                            |                                                          |
| Mental Health PHP Child                                                                   | <input type="checkbox"/> Yes <input type="checkbox"/> No |                                            |                                                          |
| Mental Health Eating Disorder Adult                                                       | <input type="checkbox"/> Yes <input type="checkbox"/> No |                                            |                                                          |
| Mental Health Eating Disorder Adolescent                                                  | <input type="checkbox"/> Yes <input type="checkbox"/> No |                                            |                                                          |
| Mental Health Eating Disorder Child                                                       | <input type="checkbox"/> Yes <input type="checkbox"/> No |                                            |                                                          |

Services Provided (indicate all services available):

Other:

Hours of Operation:

Emergency/Crisis Services Availability:

#### AFTER HOURS ACCESSIBILITY FOR PATIENTS IN TREATMENT

Answering Machine:  Answering Service:  Not Available:   
After Hours Telephone Number:

#### LIABILITY INSURANCE INFORMATION

*Attach copy of current liability face sheet:*

Current Carrier:   
Policy Number:  Policy Effective/Expiration Dates:   
Coverage Amount Per Occurrence:  Coverage Amount Aggregate:   
Include list of claims history:

#### ORGANIZATION PROFESSIONAL INFORMATION

*If any of the following questions are answered yes, attach a detailed explanation.*

YES NO

- |                                                                                                                                                                                                                                           |                          |                          |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------|
| 1. Has your facility/program had any professional liability actions? (Pending, settled, arbitrated, mediated or litigated)<br><i>If yes, provide information separately.</i>                                                              | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Has your organization liability coverage ever been cancelled, restricted, declined or not renewed by the carrier based on your liability history?                                                                                      | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Has any government agency ever investigated, suspended, revoked or taken any other action against the facility/program's license to practice?                                                                                          | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. At any time, has any license or certification ever been voluntarily or involuntarily relinquished, denied, suspended, revoked, restricted; or are there any actions which could possibly lead to such conclusions now underway?        | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Has there been any challenge to the facility/ program licensure, registration or certification?                                                                                                                                        | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. At any time, have any memberships in a professional organization ever been revoked, reduced, denied or suspended by others or voluntarily given up by the facility or are any actions that may lead to such conclusions now under way? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Has the facility/program ever been suspended, excluded from, disciplined, excluded from receiving payment under Medicare, Medicaid or TRICARE programs?                                                                                | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Has the facility/program ever been removed, sanctioned or suspended from membership in professional association for violation(s) of ethical code of practice?                                                                          | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Have any deficiencies been cited on State DOH Standard and/or Complaint Inspections, during the last 3 years?                                                                                                                          | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Have Federal fines/Federal payment denials incurred during the last 3 years?                                                                                                                                                          | <input type="checkbox"/> | <input type="checkbox"/> |

#### CONSENT TO RELEASE INFORMATION/ATTESTATION

I hereby understand and agree that, as part of the credentialing application process for participation with US Family Health Plan (hereinafter, referred to as "USFHP") at SVC MC, Inc. (hereinafter, referred to as "SVC MC"), this organization is required to provide sufficient and accurate information for a proper evaluation of its current licensure, clinical competence, character, ethics, and any other criteria used by USFHP for determining initial and ongoing eligibility for Participation. USFHP and its representatives, employees, and agent(s) acknowledge that the information obtained relating to the application process will be held confidential to the extent permitted by law.

I acknowledge that USFHP has its own criteria for acceptance, and this organization may be accepted or rejected. I further acknowledge and understand that this organization's cooperation in obtaining information and this organization's consent to the release of information do not guarantee that USFHP participation.

I hereby authorize USFHP at SVC MC including, without limitation, their representatives and/or designated agents to investigate information, which includes both oral and written statements, records, and documents, concerning this organization's application for participation. This organization agrees to allow USFHP to inspect and copy all records and documents relating to such an investigation.

I authorize any third party, including, but not limited to, individuals, agencies, medical groups responsible for credentials verification, past or present malpractice insurance carriers and other verification and review sources with which this organization has been associated with, to release to USFHP information, including otherwise privileged or confidential information, concerning this organization's professional qualifications, credentials, clinical competence, quality assurance and utilization data, ethical character, or any other matter reasonably having a bearing on this organization's qualifications for Participation in, or with, USFHP. This organization authorizes its current and past professional liability carrier(s) to release its history of claims that have been made and/or are currently pending against it. This organization specifically waives written notice from any entities and individuals who provide information based upon this Authorization, Attestation and Release.

I release from all liability and hold harmless all individuals, hospitals and other organizations which provides information to USFHP for their acts performed in good faith and without malice unless such acts are due to the gross negligence or willful misconduct of USFHP in connection with the gathering, release and exchange of, and reliance upon, information used in accordance with this Authorization, Attestation and Release. This organization further agrees not to sue USFHP for their acts, defamation or any other claims based on statements made in good faith and without malice or misconduct of such USFHP in connection with the credentialing process. In this Authorization, Attestation and Release USFHP retains the right to allow access to the application information for purposes of a credentialing audit their auditors to the extent required in connection with an audit of the credentialing processes and provided that their auditor executes an appropriate confidentiality agreement. This organization understands and agrees that this Authorization, Attestation and Release is irrevocable for any period during which this organization is an applicant for Participation at USFHP. I agree that information obtained in accordance with the provisions of this Authorization, Attestation and Release is not and will not be a violation of my privacy.

I hereby attest that information provided by this organization in its application is current, true, correct, accurate and complete to the best of my knowledge and belief, and is furnished in good faith. This organization will notify USFHP within 10 days of any material changes to the information (including any changes/challenges to licenses, DEA, insurance, malpractice claims, etc.) this organization has provided in its application or authorized to be released pursuant to the credentialing process. This organization understands that corrections to the application are permitted at any time prior to a determination of Participation by USFHP, and must be submitted online or in writing, and must be dated and signed by me (may be a written or an electronic signature). I acknowledge that USFHP will not process an application until they deem it to be a complete application and that this organization is responsible to provide a complete application and to produce adequate and timely information for resolving questions that arise in the application process. I understand and agree that any material misstatement or omission in the application may constitute grounds for withdrawal of the application from consideration; denial or revocation of Participation; and/or immediate suspension or termination of Participation. This action may be disclosed to USFHP. This organization further acknowledges that it has read and understands the foregoing Authorization, Attestation and Release. This organization understands and agrees that a facsimile or photocopy of this Authorization, Attestation and Release shall be as effective as the original.

I hereby attest that the information documented on this application is accurate and true to the best of my knowledge.

Signature:

Print Name:

Date: