Coordinated Behavioral Health Management
Facility/Center
Credentialing Application

Thank you for your interest in becoming a participating Coordinated Behavioral Health Management (CBHM) provider with Health Alliance Plan (HAP) and HAP CareSource. This application should be completed by:

- Autism centers
- Inpatient, Residential, Addiction Disorder Facilities
- Partial Day Hospital
- Outpatient Ambulatory Facilities

To begin the credentialing process, please follow the instructions below.

1. Review the credentialing criteria (Appendix A).
2. Refer to the requirements checklist on the next page.
3. Complete the application.
4. Sign and date the application.
5. Email completed application and **required** documents to providernetwork@hap.org. **Please put "behavioral health application" in the subject line.**

Please be sure to complete the entire application including the appropriate sections for your provider type. Incomplete applications will be returned.

Pending approval of your application, we will send the appropriate contracts for your review and signature.

Thank you!

Requirements Checklist

For	Required documents to submit
All Providers	• Accreditation proof for the area you are applying (AOA, CARF, NCQA or JCAHO) • Brief description of services provided (mental health, chemical dependency for adult, adolescent, children, autism treatment services, etc.) • Copy of Type 2 NPI number • HAP's Disclosure of Ownership and Control Interest Statement form • Liability insurance with coverage limits of at least $1 million/$3 million (covering all practicing clinicians) or each professional staff member must possess liability coverage with minimum coverage amounts of $100,000/$300,000 • Michigan license if applicable • Proof of Medicare and Medicaid participation, if applicable • Staff roster or summary description of professional clinical staff (BCBA, PhD, MSW, etc.) Note: Medical Director is required to be credentialed by HAP.
Autism Center/Facility	• Explanation if center is not accredited and does not have a medical director. A waiver may be requested. A site visit may be required if these guidelines are not met. • Detailed list of all treatment interventions with descriptions that will be used with HAP and HAP CareSource members Note: Applied behavior analysis must be provided or supervised by a board-certified Behavior Analyst who has a license in the State of Michigan
Inpatient Program – Mental Health	• Copy of milieu schedule showing OT, RT, education, therapy, etc.
Inpatient Residential Chemical Dependency Facility	• Therapeutic milieu schedule group, didactics, etc. • Outline of didactics regularly provided • Written admission procedure
Intensive Outpatient Program-Chemical Dependency	• Copy of assessment form used for admission to CD IOP • Coordination of care with primary care physician policy/protocol • Description of treatment program • Discharge planning form or protocol • Treatment plan form

Section 1
Must be completed by all providers

Please check appropriate box for your provider type and refer to sections to complete.

X	For
	Autism Center
	Inpatient Program – Mental Health
	Inpatient Residential Chemical Dependency Facility
	Intensive Outpatient Program–Chemical Dependency
	Outpatient Facility (Mental Health/Chemical Dependency)
	Partial Hospital Program – Mental Health
	Residential Treatment Center

Facility/Clinic/Center Information **(For additional sites, complete section 2. If location has a different Tax ID complete a separate application).**		
Facility/clinic/center name:		
Parent company (if applicable):		
Group NPI:		Tax ID:
Medicare Certificate Number:		CHAMPS #:
Site 1 street address:		
City, State, Zip:		
Phone:	Fax:	Email:
Hours of operation:		
Site 2 street address:		
City, State, Zip:		
Phone:	Fax:	Email:
Hours of operation:		
Site 3 street address:		
City, State, Zip:		
Phone:	Fax:	Email:
Hours of operation:		
Site 4 street address:		
City, State, Zip:		
Phone:	Fax:	Email:
Hours of operation:		

Contact Person Completing Form		
Full name:		
Title:		
Phone:	Fax:	Email:

Credentialing Contact Person (if same as contact person above, put N/A next to full name below)		
Full name:		
Title:		
Phone:	Fax:	Email:

Contracting Contact Person (if same as contact person above, put N/A next to full name below).		
Full name:		
Title:		
Phone:	Fax:	Email:

Billing (Pay To) Information		
Billing street address:		
City, State, Zip:		
Billing phone:	Fax:	Email:
Contact person name:		

Previous HAP OR HAP CareSource Contracting

Has your facility/center contracted with HAP or HAP CareSource at any other time, either under its current name or any other name?

☐ No ☐ Yes, Name:

Patient Restrictions– Check all that apply

☐ Treat adolescents (under 18) ☐ Treat adults (18-64) ☐ Treat geriatric (65+)

If there are any patients you cannot service, please explain.

Key Administrative Staff
Complete all sections that apply

Clinical Director Name:		
Degree:	MI License #:	Number of hours on site, per week:
Office street address:		
Office city, ST, Zip:		
Phone:	Email:	

Medical Director Name:		
Degree:	MI License #:	Number of hours on site, per week:
Office street address:		
Office city, ST, Zip:		
Phone:	Email:	

Addictionologist name:

☐ Board Certification ☐ ASAM Certification ☐ Addiction Psychiatry

Accreditation Information

JCAHO	Date issued:	Expiration Date:
Council on Accreditation (COA)	Date issued:	Expiration Date:
American Osteopathic Association	Date issued:	Expiration Date:
Commission on Accreditation of Rehabilitation Facility (CARF)	Date issued:	Expiration Date:
Other:	Date issued:	Expiration Date:

Note: If not accredited, a site visit is required.

Liability/Malpractice Insurance

Carrier Name:

Coverage amount:

Are all staff, employed or contracted (including MDs), covered by the facility's malpractice insurance policy?

☐ Yes ☐ No (enclose copy of their current malpractice insurance).

Sanctions
Have there been any settled malpractice claims, suits, settlements or proceedings involving your Organization within the past 5 years? ☐ Yes ☐ No
Has your Organization ever been disciplined, fined, excluded from, debarred, suspended, reprimanded, sanctioned, censured, disqualified or otherwise restricted in regard to participation in the Medicare or Medicaid program, or in regard to other federal or state governmental health care plans or programs? ☐ Yes ☐ No
Has an officer of your Organization ever been convicted of, pled guilty to, or pled "no lo contendere" to any felony including an act of violence, child abuse or a sexual offense? ☐ Yes ☐ No

Autism Center Only
☐ Center-based ABA ☐ In-home ABA Service area: • Applied Behavior Analysis must be provided or supervised by a Board-Certified Behavior Analyst who has a license in the State of Michigan • Autism providers should include additional explanation if their center is not accredited and does not have a medical director. A waiver may be requested. A site visit may be required if these guidelines are not met.

Inpatient Residential Chemical Dependency Facility Only - Scope of Inpatient Services Mark box if service provided for that age group and include frequency of occurrence.		
Service Description	**Adolescent**	**Adult**
1. Subacute detoxification for:		
a) Alcohol		
b) Benzodiazepines		
c) Opioids		
2. Opioid treatment program		
3. Daily medical management during acute detox		

Section 2
Additional Locations

Facility name:		
Parent company (if applicable):		
Group NPI:	Tax ID:	
Street address:		
City, State, Zip:		
Phone:	Fax:	Email:
Hours of operation:		
Facility name:		
Parent company (if applicable):		
Group NPI:	Tax ID:	
Street address:		
City, State, Zip:		
Phone:	Fax:	Email:
Hours of operation:		
Facility name:		
Parent company (if applicable):		
Group NPI:	Tax ID:	
Street address:		
City, State, Zip:		
Phone:	Fax:	Email:
Hours of operation:		
Facility name:		
Parent company (if applicable):		
Group NPI:	Tax ID:	
Street address:		
City, State, Zip:		
Phone:	Fax:	Email:
Hours of operation:		

For additional locations, attach a list including the same information above. If location has a separate Tax ID #, please complete a separate application

Appendix A
Credentialing Criteria

Please see the table below for the minimum requirements for the accepted professional categories that may provide services under a HAP and HAP CareSource contracted behavioral health facility.

Professional Category	Minimum Requirements
Certified Addiction Counselor	• Current Michigan certification as a Certified Addiction Counselor • Bachelor's degree in an area accepted as entrance to certification examination
Fully Licensed Psychologist	• Current Michigan license to practice as a Licensed Psychologist with verifiable current competence • Doctoral degree in psychology from an institution and with a curriculum approved by the State of Michigan Board of Psychology
Licensed Marriage and Family Therapist	• Current Michigan license to practice as a Licensed Marriage and Family Therapist, with verified current competence • Master's degree or higher graduate degree from a board approved training program in marriage and family therapy • Master's degree and higher graduate degree from a board-approved college or university that meets accreditation standards • Affiliation with a HAP contracted behavioral health clinic
Licensed Master's Social Worker	• Current Michigan license to practice as a Licensed Social Worker with verifiable current competence • Master's degree in social work (MSW) with a major focus of study in the treatment of behavioral medicine or equivalent field, as defined by the Michigan Board of Examiner of Social Work
Limited License Psychologist/LLP	• Current Michigan license to practice as a Limited License Psychologist with verifiable current competence and in conformance with licensing requirements regarding professional supervision • Master's or doctoral degree in psychology from an institution and with a curriculum approved by the Michigan Board of Psychology
Licensed Professional Counselor	• Current Michigan license to practice as a Licensed Professional Counselor with verifiable current competence and in conformance with licensing requirements regarding professional supervision • Master's degree from a program approved by the state Board of Counseling
Physician Assistant	• Current unrestricted Michigan license to practice as Physician's Assistant • Completion of a Physician's Assistant training program accredited by the Commission on Accreditation of Allied Health Education Programs (CAAHEP) • Successful completion of the certifying examination conducted and scored by the National Commission on Certification of Physician Assistants • Three years of full-time, supervised Behavioral Medicine clinical experience following completion of training. Acceptable behavioral health settings may include but are not limited to any of the following: psychiatric inpatient unit, sub-acute detoxification unit, ambulatory mental health or chemical dependency clinic, specialized nursing home behavioral health unit, neuropsychiatric unit, child psychiatry unit, adolescent mental health or chemical dependency unit, mental health or chemical dependency partial hospital program, chemical dependency rehabilitation program • Current supervision arrangement with a HAP/PHP contracted psychiatrist or HAP contracted facility
Psychiatric Clinical Nurse Specialist	• Current Michigan License to practice as a Registered Nurse (RN), and • Current Michigan specialist certification in one of the following: – Clinical Specialist in adult psychiatric and mental health nursing – Clinical Specialist in adolescent and child psychiatric and mental health nursing – Psychiatric and mental health nursing and verifiable current competence • Master's degree in nursing from an institution acceptable to the state of Michigan with concentration in psychiatric/mental health nursing
Psychiatrist/ Physician	• Current Michigan license to practice as an M.D. or D.O., with verifiable current competence • Board certification in adult and/or child psychiatry, or recent completion of a board- approved residency or fellowship in adult and/or child psychiatry. (Addictionology certification, either ABMS or ASAM, is acceptable for physicians providing services in chemical dependency clinics.)

Coordinated Behavioral Health Management
Attestation

Purpose
To make applicants aware of the minimal expectations of HAP providers and to ensure that applicants are willing to comply with these.

Attestation
I, the undersigned, have read the information received with this application and acknowledge and agree to comply with the following expectations of HAP and HAP CareSource providers:

- Providers' responsibility for working with Plan staff to become knowledgeable in applicable policies and procedures; contracted providers' responsibility for educating their employees and staff in applicable policies and procedures.

- Compliance with applicable requirements regarding prior authorization for all mental health and substance abuse services, such as contacting a CBHM case manager before providing services to Plan members except in emergencies. I understand that failure to comply with this expectation may result in denial of reimbursement, for which Plan members are held harmless.

- Compliance with applicable minimum guidelines regarding delivery of services, particularly access requirements and emergency availability (or appropriate coverage) which are intended for the safety of Plan members.

- Cooperation with applicable quality assurance guidelines including prompt notification to CBHM of changes in information submitted in the application; submitting requested information about my office, practice or aggregate information about patients: providing such information as necessary to assist the Plan in fulfilling its obligation to provide high quality care to members.

- Active cooperation with the case management process, including making every effort to provide Plan case managers with accurate, timely information to assist their decision-making.

I agree to the contents thereof as evidenced by my signature that the information provided in this application is true and complete to the best of my knowledge and that omission or falsification of information may be cause for ineligibility or disaffiliation. I further agree that I have current malpractice insurance and I have disclosed the history of loss or limitation of privileges or disciplinary activity.

Signature of Applicant/Authorized Representative _____ Date _____

Title _____ Facility Name _____