

APPLICATION and DOCUMENTATION CHECKLIST



For your convenience use the checklist below to prepare your Application for return.
To ensure timely processing, please enclose the required documents listed below in addition to your completed application.

Top 3 Application Errors:

Please review the list below to ensure that you avoid
the 3 most common Application errors:

1. Section K – Provider Profile – not marking line 11b.
2. OMMITTING MM/YYYY on education and work history
3. Not Explaining Gaps in Work History Greater than 60 days

*On behalf of the Credentialing Team,
we sincerely appreciate your attention to detail!*

RETURN:
Advantage Behavioral Health
1101 Sixth Ave. North
Nashville, TN 37208
FAX: 615-460-4107
PH: 615-460-4121 or 866-726-4560

Checklist:

- Completed and signed Practitioner Application**
- Completed Form W-9 Form for each Tax Identification Number (TIN) (original signature required) List only TIN or SSN – Do not enter both
- Current Professional Liability Face sheet (**must indicate practitioner's name as the insured or supply letter of inclusion, policy period and coverage amounts**)
- Current and Past State License/Certification
- Current DEA Certificate (if applicable)
- Current State Controlled Dangerous Substances (CDS) Registration **OR** Rx # (if applicable)
- Proof of Board Certification
- Education Commission for Foreign Medical Graduates (ECFMG) Certificate (if applicable)
- Test of English as a Foreign Language (TOEFL) Certificate (if applicable)
- Work History/Curriculum Vitae/Resume (**must include month and year**). Any lapse in continuous employment/work history since graduation from your graduate degree program must be fully explained on a separate sheet.
- Current ANCC Board Certification (APNs)
- Copy of Current APN Collaboration Agreement with Psychiatrists (if applicable)

Criteria for Network Participation

Before completing the Practitioner Application, please review the following criteria required for network practitioners. Note: This check off sheet is provided for your convenience, please use to ensure you meet minimum criteria and to ensure your required materials are included with your completed application packet.

1. Please review the applicable section for your discipline **ONLY**.
2. Check the criteria met in each box,

PSYCHIATRISTS

- Must possess a Doctor of Medicine (MD) degree or Doctor of Osteopathy (DO) degree from an accredited medical school.
- Board certified in psychiatry as defined by the American Board of Psychiatry and Neurology **OR** Certified by the American Society of Addiction Medicine (ASAM) or the American Board of Psychiatry and Neurology in Addiction Medicine **OR** Graduated from an accredited residency program.
- Licensed to practice medicine in the state where practice is to occur.
- Must possess a current Drug Enforcement Administration (DEA) Certificate.
- Completed a training program approved by the American Council of Graduate Medical Education (ACGME) or Osteopathic-approved residency training program in psychiatry.
- Must possess a State Controlled Dangerous Substances (CDS) Registration Certificate (where applicable)
- Graduates of foreign medical schools must submit an Educational Commission for Foreign Medical Graduates (ECFMG) certificate.
- All eligible providers must have a minimum of three (3) years residency experience in a mental health/substance abuse setting providing direct patient care.
- Possess professional liability coverage at a minimum level of \$1,000,000 per episode and \$3,000,000 aggregate. *Exceptions will be made if allowed by the State of Tennessee.* Copy of current face sheet must be included (**must list applicant name as the insured, policy period and coverage amounts**).
- Primary admitting privileges or designate an in-network physician or facility.

ADDICTIONOLOGIST (non-PSYCHIATRIST)

- Must possess a Doctor of Medicine (MD) degree or Doctor of Osteopathy (DO) degree from an accredited medical school.
- Certified by the American Society of Addiction Medicine (ASAM) as an addictions specialist.
- Licensed to practice medicine in the state where practice is to occur.
- Must possess a current Drug Enforcement Administration (DEA) Certificate.
- Must possess a State Controlled Dangerous Substances (CDS) Registration Certificate (where applicable)
- Graduates of foreign medical schools must submit an Educational Commission for Foreign Medical Graduates (ECFMG) Certificate.
- All eligible providers must have a minimum of three (3) years residency experience in a mental health/substance abuse setting providing direct patient care.
- Possess professional liability coverage at a minimum level of \$1,000,000 per episode and \$3,000,000 aggregate. *Exceptions will be made if allowed by the State of Tennessee.* Copy of current face sheet must be included (**must list applicant name as the insured, policy period and coverage amounts**).
- Primary admitting privileges or designate an in-network physician or facility.

PSYCHOLOGISTS

- Must possess Doctoral degree (PhD, EdD, PsyD) in clinical psychology or counseling psychology from an accredited college or university **AND** meet one of the following:
 - a. Doctorate was received from a college program on the American Psychological Association (APA) approved list of counseling psychology or clinical psychology programs **at the time of graduation OR**
 - b. Completion of a pre-doctoral APA approved clinical internship **at the time of graduation OR**
 - c. Listed in the National Register of Health Service Providers in Psychology **OR**
 - d. Be a diplomate with the American Board of Professional Psychology (ABPP) under the clinical psychology or counseling psychology categories.

Note: A **respecialization** in clinical psychology or counseling psychology is eligible with proof of completion of training.
- Licensed independently as a clinical psychologist at the highest level in the state where practice is to occur.
- All eligible providers must have a minimum of three (3) years post-licensure clinical experience in the direct provision of mental health and/or substance abuse setting providing direct patient care.
- Possess professional liability coverage at a minimum level of \$1,000,000 per episode and \$3,000,000 aggregate. *Exceptions will be made if allowed by the State of Tennessee.* Copy of current face sheet must be included (**must list applicant name as the insured, policy period and coverage amounts**).

SOCIAL WORKERS

- Must possess Master's degree or higher from a graduate school of social work accredited by the Council on Social Work Education (CSWE).
- State licensed or certified to practice at the highest level of independent practice in the state where practice is to occur.
- All eligible providers must have a minimum of three (3) years post-licensure clinical experience in a mental health/substance abuse setting providing direct patient care.
- Possess professional liability coverage at a minimum level of \$1,000,000 per episode and \$1,000,000 aggregate. *Exceptions will be made in states where the maximum amount of coverage obtainable is less than the limits above.* Copy of current face sheet must be included (**must indicate applicant as the insured, policy period and coverage amounts**).

ADVANCED PRACTICE NURSE (APN)

- State licensed to practice as a nurse at the highest level of independent practice in the state where practice is to occur
- Must possess Master's degree or higher in nursing from an accredited college or university in a program recognized by the National League for Nursing **OR** must meet licensing requirements acceptable by the board to practice at the highest level of independent practice in the state where practice is to occur.
- Must possess a current Drug Enforcement Agency (DEA) Certificate (if applicable for prescriptive authority).
- Must possess a current State Controlled Dangerous Substances (CDS) Registration (if applicable for prescriptive authority).
- Rx Number or Certification issued to the APN in order to provide prescriptive authority (if applicable for prescriptive authority).
- Certified by the American Nurses Association, American Nurses Credentialing Center (ANCC) as an APRN, Board Certified (BC). The certification held must be in **one** of the following areas:
 - Clinical Specialist in Adult Psychiatric and Mental Health Nursing
 - Clinical Specialist in Child and Adolescent Psychiatric & Mental Health Nursing
 - Family Psychiatric and Mental Health Nurse Practitioner
 - Adult Psychiatric and Mental Health Nurse Practitioner.(Please note: The APRN, BC certification is a new credential approved by the ANCC.
- All eligible providers must have a minimum of three (3) years post-licensure experience in a mental health/substance abuse setting providing direct patient care.
- The APN is required to maintain compliance with collaboration/supervision licensing requirements issued by the State(s) in which practice occurs. In states that require the APN to hold a collaborative agreement with a physician, ValueOptions requires the APN to be supervised by a psychiatrist (MD or DO). The APN must submit a copy of the agreement.
- APNs with prescriptive authority must possess professional liability coverage at a minimum level of \$1,000,000 per episode and \$3,000,000 aggregate. APNs without prescriptive authority must possess professional liability coverage at a minimum level of \$1,000,000 per episode and \$1,000,000 aggregate. *Exceptions will be made if allowed by the State of Tennessee.* Copy of current face sheet must be included (**must list applicant name as the insured, policy period and coverage amounts**).

MASTER'S LEVEL COUNSELORS (LPC, LMFT, Psychological Examiners, Mental Health Counselors)

- Must possess Master's degree or higher in a mental health discipline from a regionally accredited college or university.
- State licensed or certified to practice independently in the state where practice is to occur. Only acceptable in those states where clinical experience and exam requirements equal or exceed 2 years or 2,000 hours of clinical experience or 1,000 hours of direct clinical contact (face-to-face) under an approved supervisor as defined by the appropriate state regulatory agency. Must have received 100 hours of face-to-face supervision by an approved supervisor (as defined by the state) during the first two years of post-graduate direct clinical experience.
- All eligible providers must have a minimum of three (3) years post-licensure clinical experience in a mental health/ substance abuse setting providing direct patient care.
- Possess professional liability coverage at a minimum level of \$1,000,000 per episode and \$3,000,000 aggregate. *Exceptions will be made if allowed by the State of Tennessee.* Copy of current face sheet must be included (**must list applicant name as the insured, policy period and coverage amounts**).

Please Note: Practitioners have the right to review information submitted in support of their credentialing application. All requests for documentation must be submitted in writing. Advantage Behavioral Health will not release information obtained through the primary source verification process, when disclosure is prohibited by law.

PRACTITIONER APPLICATION

ALL HIGHLIGHTED AREAS IN THE APPLICATION MUST BE COMPLETED

A. PROVIDER INFORMATION - DEMOGRAPHICS:

Last Name		First Name		Middle Initial	<input type="checkbox"/> Male <input type="checkbox"/> Female
Mailing Address Line 1		Mailing Address Line 2		NPI Number	
City	County	State	Zip	Phone FAX Mail email Preferred Contact Method (Circle One)	
Telephone (include area code)		FAX (include area code)		Degree	
Social Security Number (REQUIRED)		Tax Identification Number (REQUIRED)		Date of Birth (REQUIRED)	
				Place of Birth (City, State, Country) (REQUIRED)	
Medicaid Number (or state N/A)	MEDICARE Number (or state N/A)	OFFICE Contact Name:		Office Contact Number:	
Indicate any other name you may have used in the past (e.g., maiden name, etc.)			Internet E-mail address (if applicable)		

LICENSED DISCIPLINE: Indicate the discipline under which you are LICENSED and/or CERTIFIED at the highest level to practice independently.

- | | |
|--|--|
| <input type="checkbox"/> Psychiatrist | <input type="checkbox"/> CAC, CADS, NCAC, etc. |
| <input type="checkbox"/> Child Psychiatrist | <input type="checkbox"/> Licensed Professional Counselor/Mental Health Counselor |
| <input type="checkbox"/> Psychologist | <input type="checkbox"/> Marriage & Family Therapist/Marriage Family & Child Counselor |
| <input type="checkbox"/> Social Worker | <input type="checkbox"/> Pastoral Counselor |
| <input type="checkbox"/> Registered Nurse or Nurse Practitioner | <input type="checkbox"/> Other (specify): _____ |
| <input type="checkbox"/> Advanced Practice Nurse w/ prescriptive auth. | |

B. PRIMARY PRACTICE INFORMATION

If Multiple Service Locations enter other locations(s) below under "Other Practice Locations".

Practice Name					
Practice Address Line 1 (street address required for referral purposes)			Practice Address Line 2		
City	County	State	Zip	Appointment Telephone (include area code)	
Office Manager (if applicable)				Fax Number	

Make checks payable to (must match tax ID owner name on file with IRS for the TIN provided)

Billing Address Line 1			Billing Address Line 2		
City	County	State	Zip	Telephone (include area code)	
Tax Identification Number (TIN) <i>Must submit a substitute W-9 form for each tax ID used</i>			Your Medicare/UPIN Number		Your Medicaid Number

Hours of Operation (actual practice hours each day at this location, e.g., 8:00am to 4:30pm):

Monday		Tuesday		Wednesday		Thursday		Friday		Saturday	
From	To	From	To	From	To	From	To	From	To	From	To

Is this office handicapped accessible? Yes No

Is this office accessible to public transportation? Yes No

Other Practice Location(s)

(If you have **more than two** practice locations **copy this page before completing**)

Practice Name					
Practice Address Line 1 (street address required for referral purposes)			Practice Address Line 2		
City	County	State	Zip	Appointment Telephone (include area code)	
Office Manager (if applicable)			Fax Number		

Make checks payable to (must match tax ID owner name on file with IRS for the TIN listed below)

Billing Address Line 1			Billing Address Line 2		
City	County	State	Zip	Telephone (include area code)	
Tax Identification Number (TIN) <i>Must submit a substitute W-9 form for each tax ID used</i>			Your Medicare/UPIN Number	Your Medicaid Number	

Hours of Operation (actual practice hours each day at this location, e.g., 8:00am to 4:30pm):

Monday		Tuesday		Wednesday		Thursday		Friday		Saturday	
From	To	From	To	From	To	From	To	From	To	From	To

Is this office handicapped accessible? Yes No

Is this office accessible to public transportation? Yes No

Answering Service: Indicate how you can be reached after hours.

Answering Service Name	Phone #:
Pager or Beeper #	Voice Mail #

BILLING INFORMATION:

1. Does your office have electronic billing capacity? Yes No

If yes, check one or more of the following:

- Software Vendor List software: _____
- Claims Clearinghouses List vendor: _____
- Billing Service List vendor: _____

2. I will be signing my own claim forms. Yes No

3. I belong to an incorporated group/professional association. Yes No

If yes, my affiliation with incorporated group/professional association began on _____ (date).

C. REFERRAL INFORMATION – NOTE % of Practice should equal 100%

Identify the percentage of your practice dedicated to the following patient population categories (must total 100%):

Population	% of Practice	Are You Currently Accepting New Patients?	Modality	% of Practice
Young Child (0-5) (YC)		⇒ <input type="checkbox"/> Yes <input type="checkbox"/> No	Inpatient	
Child (6-12) (CI)		⇒ <input type="checkbox"/> Yes <input type="checkbox"/> No	Day Treatment	
Adolescent (13-17) (AO)		⇒ <input type="checkbox"/> Yes <input type="checkbox"/> No	Outpatient	
Adult (18-64) (AU)		⇒ <input type="checkbox"/> Yes <input type="checkbox"/> No	Intensive Outpatient Programs	
Geriatric (65+) (GT)		⇒ <input type="checkbox"/> Yes <input type="checkbox"/> No		

Identify any foreign language(s) or sign language that you use fluently in treating patients (select no more than 5):

- | | | | |
|---|------------------------------------|-------------------------------------|---|
| <input type="checkbox"/> American Sign Language | <input type="checkbox"/> French | <input type="checkbox"/> Italian | <input type="checkbox"/> Russian |
| <input type="checkbox"/> Arabic | <input type="checkbox"/> German | <input type="checkbox"/> Japanese | <input type="checkbox"/> Spanish |
| <input type="checkbox"/> Armenian | <input type="checkbox"/> Greek | <input type="checkbox"/> Korean | <input type="checkbox"/> Swedish |
| <input type="checkbox"/> Chinese | <input type="checkbox"/> Hebrew | <input type="checkbox"/> Norwegian | <input type="checkbox"/> Tagalog/Filipino |
| <input type="checkbox"/> Dutch | <input type="checkbox"/> Hindi | <input type="checkbox"/> Polish | <input type="checkbox"/> Vietnamese |
| <input type="checkbox"/> Farsi | <input type="checkbox"/> Hungarian | <input type="checkbox"/> Portuguese | <input type="checkbox"/> Yiddish |
| <input type="checkbox"/> Other: _____ | | | |

CLINICAL EXPERTISE (SPECIALTIES):

From the list below, **select up to five (5) specialty areas** for which you have training and expertise. These specialties will be used in making clinically appropriate referrals.

- | | | |
|--|--|--|
| <input type="checkbox"/> Addictions, Non-Chemical | <input type="checkbox"/> Family Violence (S.VIO) | <input type="checkbox"/> Obsessive Compulsive Disorder (S.OCD) |
| <input type="checkbox"/> Anger Management | <input type="checkbox"/> Gay/Lesbian/Bisexual Issues (810P) (S.GLS) | <input type="checkbox"/> Personality Disorders (190P) (S.PER) |
| <input type="checkbox"/> Alcohol / Chemical Dependency | <input type="checkbox"/> Head Trauma | <input type="checkbox"/> Severe & Persistent Mental Illness |
| <input type="checkbox"/> Childhood Behavioral Problems / Attention Deficit Hyperactivity Disorder (ADHD)/School-related problems (S.ADD) | <input type="checkbox"/> Hearing Impaired | <input type="checkbox"/> Sex Abuse Victims or Perpetrators |
| <input type="checkbox"/> Chronic Pain/Terminal Illness / Grief | <input type="checkbox"/> HIV / AIDS | <input type="checkbox"/> Sexual Dysfunction |
| <input type="checkbox"/> Disability Treatment | <input type="checkbox"/> Marital/Separation/Divorce | <input type="checkbox"/> Sleep Disorders |
| <input type="checkbox"/> Dissociative Identity Disorders | <input type="checkbox"/> Men's Issues | <input type="checkbox"/> Women's Issues |
| <input type="checkbox"/> Eating Disorders | <input type="checkbox"/> Mental Retardation / Developmental Disabilities | |

THERAPEUTIC MODALITIES:

From the list below, **select up to four (4) modality areas** that you use when treating patients. These modalities will be used to assist in making clinically appropriate referrals.

- | | | |
|---|---|--|
| <input type="checkbox"/> Brief Therapy (211) (M.BRF) | <input type="checkbox"/> ECT Outpatient | <input type="checkbox"/> Neuropsych Testing (370T) (M.NSY) |
| <input type="checkbox"/> Child Therapy (M.CHI) | <input type="checkbox"/> ECT Inpatient | <input type="checkbox"/> Psych Testing (M.PST) |
| <input type="checkbox"/> Family Therapy (214) (M.FAM) | Other: _____ | <input type="checkbox"/> Psychopharmacology (M.PSP) |
| <input type="checkbox"/> Group Therapy (215) (M.GRP) | _____ | |

SERVICES OFFERED: Please indicate if you provide services in any of the following areas.

- Case management services Specify: _____
- Emergency assessment and counseling (*Contact patient by telephone within 45 minutes*)
- In home care
- Suicide assessment/intervention (*Contact patient by telephone immediately*)
- Urgent/crisis intervention services
- Mandatory Prescreener (MPS) (*per Title 33, State of Tennessee Mental Health law*)(*need clarification if licensed or consider under a program*)

D. CLINICAL PRIVILEGES (ONLY REQUIRED FOR MD/DO):

If NOT Applicable, mark NA and advance to Section E.

NA

****Check here if NA.**

List below, if applicable, your current clinical privileges and the type of clinical privilege granted to you by your admitting facility. **The Primary Admitting Facility should be the facility at which you admit/treat most of your patients.**

Common Types of Clinical Privileges held:

Active- active physicians or practitioners, who use the hospital frequently, vote & hold office

Courtesy- staff members who infrequently utilize the hospital

Consulting-practitioners who provide a desired skill or specialty

Do you currently hold clinical privileges Yes No

Primary Admitting Facility	Address	JCAHO OR CARF Accredited?	Type of Clinical Privilege Granted/Held
		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Other Admitting Facility	Address	JCAHO OR CARF Accredited?	Type of Clinical Privilege Granted/Held
		<input type="checkbox"/> Yes <input type="checkbox"/> No	
		<input type="checkbox"/> Yes <input type="checkbox"/> No	

If you **do not** have admitting privileges, list the name(s) of an in network physician or facility below to whom you would refer.

E. EDUCATIONAL INFORMATION: (REQUIRED for verification purposes – MM/YYYY REQUIRED)

Months and Years

Educational Institution (include name and <u>complete</u> address)		Degree	From (mm/yyyy)	To (mm/yyyy)
Undergraduate	Institution: Address: City, State, Zip:			
Graduate/ Medical School	Institution: Address: City, State, Zip:			
Internship	Institution: Address: City, State, Zip:		/	/
Residency	Institution: Address: City, State, Zip:		/	/
Fellowship	Institution: Address: City, State, Zip:			

F. ECFMG:

If you are a foreign medical school graduate, are you certified by the Educational Commission for Foreign Medical Graduates (ECFMG)? If the answer is yes, please include a copy of your certificate Yes No

G. LICENSURE AND CERTIFICATIONS:

1. PROFESSIONAL LICENSE(S):



LIST ALL health care licenses held in the past ten (10) years. Indicate original licensure date through current expiration date for each state in which you are or have been licensed/certified.

An explanation is REQUIRED for any license that is no longer current, whether by voluntary relinquishment or disciplinary or other action. Attach an additional sheet if necessary.

Licensing Board Name	State	Specify Active or Inactive	Certificate #	Original Issue Date (mm/dd/yy)	Expiration Date (mm/dd/yy)
				/ /	/ /
				/ /	/ /
				/ /	/ /

2. DEA/CDS CERTIFICATES:

List your current DEA Certificate and Controlled Dangerous Substances registration information, if applicable.

Be sure to include a current copy of your certificate(s) with your application materials.

DEA Certificate #	Exp. Date
	/ /

CDS Registration #	State	Exp. Date
		/ /

State Issued Rx #	Exp. Date
	/ /

3. BOARD CERTIFICATION/SPECIALTY:

List below any certifications you have received from any nationally recognized specialty boards.

PRINCIPAL SPECIALTY	Name of Board (if board certified)
Exam Information (check one):	
<input type="checkbox"/> Oral exam taken <input type="checkbox"/> Oral exam scheduled <input type="checkbox"/> Written exam taken <input type="checkbox"/> Written exam scheduled <input type="checkbox"/> No plans to take	
Exam Date: / /	Date Certified: / / Re-exam Date: / /

SECONDARY SPECIALTY	Name of Board (if board certified)
Exam Information (check one):	
<input type="checkbox"/> Oral exam taken <input type="checkbox"/> Oral exam scheduled <input type="checkbox"/> Written exam taken <input type="checkbox"/> Written exam scheduled <input type="checkbox"/> No plans to take	
Exam Date: / /	Date Certified: / / Re-exam Date: / /

4. ADDITIONAL CERTIFICATIONS:

Certification Type	Certificate #	Expiration Date (mm/dd/yy)
American Nursing Credentialing Center (ANCC) Board Certification (i.e., APRN, BC)		/ /
Certified Employee Assistance Professional (CEAP)		/ /
Chemical Dependency Certification (Specify: _____)		/ /

Please include a current copy of your certification with your application materials.

H. MALPRACTICE INSURANCE:

Enclose a copy of your current policy certificate and/or declarations page indicating you as the covered clinician, and showing the coverage limits and dates of coverage.



ALSO, "LIST BELOW" your current malpractice carrier. Please DO NOT mark "See Policy".

Current Carrier (Name and Certificate Number)	Dates of Coverage	Coverage Limits



Has the same carrier covered you for the past five (5) years? Yes No If NO, see below.

If you have not been covered by the same carrier for the past 5 years, list below the name and complete address of any other malpractice carrier who has provided coverage for you for the most recent five (5) year period.

If there has been more than one carrier, please indicate the dates of coverage with each carrier, and the reason for changing carriers.

Carrier (Name and Complete Address)	Dates of Coverage	Reason for Changing Carriers



MALPRACTICE CLAIMS: Please provide information on pending and/or settled malpractice claims. A separate sheet may be included if necessary.

If NO CLAIMS, mark NA and advance to Section I. **NA**

****Check here if NA.**

Be as specific as possible with regard to procedures, names, dates, and actions. Explanations provided on pending and/or settled malpractice claims must include the minimum information requested below (you may use the space below, or include a separate sheet if necessary).

Patient's name:		Date of occurrence (mm/dd/yy):
Insurance company defending your claim:		
Hospital name:		
Hospital address:		
Procedures performed:		
Co-defendants:		
Court trial? <input type="checkbox"/> Yes <input type="checkbox"/> No	Settlement out of court? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of settlement (mm/dd/yy):
Allegations:		
Claim settled for no payment on your behalf? <input type="checkbox"/> Yes <input type="checkbox"/> No		Claim is pending? <input type="checkbox"/> Yes <input type="checkbox"/> No
Amount in reserve by insurance company:	Total amount paid to claimant on your behalf:	
Total amount paid to claimant for all defendants:		

I. WORK HISTORY: IMPORTANT NOTES SEE BELOW.

You must include MM/YYYY (Months and Years) – Any Gaps in work history GREATER THAN 60 days must be explained.

This section may be used to provide your work history.



A current Curriculum Vita (CV) may be submitted in lieu of completing this section mark SEE CV below. The CV must specify month and year.

Either your CV or this document must include MM /YYYY (Months and Years) of all work experience to meet credentialing standards. Use an extra page if needed.

Any lapse in continuous employment for work history since graduation from your graduate degree program must be fully explained on a separate sheet.

From (Month/Year) required	To (Month/Year)	Description of Activities
Example: 10/2004	12/2005	Sample Practice LLC, Nashville, TN – Staff Psychologist

J. ADVANCED PRACTICE NURSE (APN): This section to be completed by APN's only.

- Are you currently recognized by your state licensing board to practice as an Advanced Practice Nurse? Yes No
- Do you hold prescriptive authority in the state(s) in which you are licensed to practice? Yes No
- Are you required by your licensing board to hold a collaboration agreement with a physician? Yes No
- Does your licensing board require you to be supervised by a physician? Yes No
- If you are required to collaborate or be supervised by a physician, is the physician a psychiatrist? Yes No
- Do you have a Federal DEA certificate? Yes No
- Do you hold a state issued Controlled Dangerous Substance (CDS) Registration or Rx #? Yes No

This section to be completed by APNs who are required to collaborate or be supervised by a physician.

Name of collaborating/supervising physician: _____
Please Print

Specialty of collaborating/supervising physician _____

K. PROVIDER PROFILE: Please answer ALL provider profile questions.

NOTE: If "YES" is checked, please explain fully on a separate sheet. If NA, mark NA.

Each box must be addressed.

Documentation is **required** if you have malpractice claims pending or settled in the past five (5) years (include any settlements/adjudications, original complaint and final disposition).

The documentation must be from an attorney or the entity that issued the judgment.

1. Health Status: Do you have any physical, mental, or emotional condition, including but not limited to any history of drug or alcohol abuse, which currently impairs your ability to render the professional services which are the subject of this application? "Currently" means recently enough so that the condition could reasonably have an impact on your ability to safely and competently render the professional services which are the subject of this application.....	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Insurance Coverage: Has your professional liability insurance coverage ever been denied, canceled, or non-renewed or initially refused upon application?.....	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. License: Has your medical or professional license in any state ever been revoked, suspended, placed on probation, conditional status, or limited?.....	<input type="checkbox"/> Yes <input type="checkbox"/> No
a. Have you ever voluntarily surrendered your license?.....	<input type="checkbox"/> Yes <input type="checkbox"/> No
b. Are formal charges pending against you at this time?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. DEA: Has your DEA Registration Certificate ever been suspended, revoked, subjected to probation, placed on conditional status, or limited?.....	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
5. Hospital Privileges: Has any hospital ever dismissed you from its staff?.....	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
a. Has any hospital ever revoked, suspended, or limited your privileges?.....	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
b. Has any hospital initiated either type of the aforementioned action by formal notice to you?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
c. Has any hospital refused or denied you privileges?.....	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
d. Have you ever voluntarily surrendered your hospital privileges?.....	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
6. Hospital Sanctions: Have you ever surrendered your clinical privileges upon threat of censure, restriction, suspension or revocation of such privileges?.....	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
7. Professional Membership(s): Has your membership in any professional society or association ever been canceled, revoked, or censured?.....	<input type="checkbox"/> Yes <input type="checkbox"/> No
8. Medicare/Medicaid/TRICARE: Have you ever been fined, had an arrangement suspended, been expelled from participation or had criminal charges brought against you by any Medicare, Medicaid or TRICARE program?.....	<input type="checkbox"/> Yes <input type="checkbox"/> No
9. Criminal Offenses: Have you ever been arrested, charged with or convicted of a felony or involved in charges relating to moral or ethical turpitude, including crimes with children?.....	<input type="checkbox"/> Yes <input type="checkbox"/> No
a. Have you ever been named as a defendant in any criminal proceeding?.....	<input type="checkbox"/> Yes <input type="checkbox"/> No
10. Board Discipline: Have you ever been the subject of disciplinary proceedings by any professional association or organization (i.e., state licensing board; county, state or national professional society; hospital medical or clinical staff)?.....	<input type="checkbox"/> Yes <input type="checkbox"/> No
11. Malpractice Action: Has any malpractice action against you been brought or settled in the past 5 years or has there been any unfavorable judgment (s) against you in a malpractice action?.....	<input type="checkbox"/> Yes <input type="checkbox"/> No
a. To your knowledge, is any malpractice action against you currently pending?.....	<input type="checkbox"/> Yes <input type="checkbox"/> No
b. Please give a number of malpractice claims pending and closed: CHECK "0" if NO CLAIMS <input type="checkbox"/> None (0) <input type="checkbox"/> One (1) <input type="checkbox"/> Two (2) <input type="checkbox"/> More than 2 (please give number:_____)	Please check one box – do not leave blank.
c. Have you ever been a defendant in any lawsuit involving your practice where there has been an award or payment of \$50,000 or more?.....	
d. Have you had any malpractice claims where there has been an award or payment of \$50,000 or more?.....	<input type="checkbox"/> Yes <input type="checkbox"/> No

PROVIDER ATTESTATION STATEMENT

Signature and Date Required

This credentialing information and the attached documents contain detailed and specific information relating to my character and professional competence. I warrant that all of the information that I have provided and the responses that I have given are correct and complete to the best of my knowledge and belief. I understand that willful falsification or willful omission of this information will be grounds for rejection or termination.

I understand that this application does not entitle me to participation in the Advantage Behavioral Health Network

I release Advantage Behavioral Health(Advantage), its representatives, and any individuals or entities providing information to Advantage from liability for any act or omission related to the evaluation or verification contained in this application provided Advantage, its representatives and individuals providing information to Advantage act in good faith and without malice. I further agree to notify Advantage of any change to the information provided in this application within 30 days of any such change. I understand that any information provided in this application that is not publicly available will be treated as confidential by Advantage.

In addition to any notice required by any contract with a Healthcare Organization, I agree to notify Advantage immediately in writing of the occurrence of any of the following: (i) the unstayed suspension, revocation, limitation, restriction or nonrenewal of my license to practice in any state; (ii) any suspension, revocation, limitation, restriction or nonrenewal of my DEA or other controlled substances registration; or (iii) any cancellation, limitation, restriction or nonrenewal of my professional liability insurance coverage.

I further agree to notify Advantage in writing, promptly and no later than fourteen (14) calendar days from the occurrence of any of the following: (i) receipt of written notice of any adverse action against me by the applicable State Regulation and Licensing or the applicable State Medical Examining Board taken or pending, including but not limited to, any accusation filed, temporary restraining order, or imposition of any interim suspension, probation or limitations affecting my license to practice medicine; or (ii) any adverse action against me by any Healthcare Organization which has resulted in the filing of a report with the applicable State Regulation and Licensing or the applicable State Medical Examining Board, or a report with the National Practitioner Data Bank; or (iii) the denial, revocation, suspension, reduction, restriction, limitation, nonrenewal or voluntary relinquishment by resignation of my medical staff membership or clinical privileges at any Healthcare Organization; or (iv) any material reduction in my professional liability insurance coverage; or (v) my receipt of written notice of any legal action against me, including, without limitation, any filed and served malpractice suit or arbitration action; or (vi) my conviction of any crime (excluding minor traffic violations); or (vii) my receipt of written notice of any adverse action against me under the Medicare or Medicaid programs, including, but not limited to, fraud and abuse proceedings or convictions.

I authorize Advantage Behavioral Health and its agents and any individual or entity providing information to Advantage to investigate and evaluate my provider application, and consult with any person, organization, or entity that has, or could have any information, data, or documents regarding my background, competence, and credentials.

Date (mm/dd/yy) _____

Provider Signature (Sign in script/cursive)

Name (Please Print)

Degree

RETURN COMPLETED APPLICATION TO:

Advantage Behavioral Health

1101 Sixth Avenue North

Nashville, TN 37208

Or

Fax to: 615-460-4107

Or

E-mail to: kathy.campbell@advantagebehavioral.org