Horizon Blue Cross Blue Shield of New Jersey
ANCILLARY BEHAVIORAL HEALTH CREDENTIALING APPLICATION

Instructions

- Complete a separate application **for each service location, as needed**.
- Complete this application in its entirety. Missing information/documentation will delay application processing.

Required for all submissions:

- ☐ Ancillary Behavioral Health Credentialing Application
- ☐ License that includes license number, expiration date and restrictions, if applicable
- ☐ Certificate of Insurance that includes business liability and professional liability, if applicable
  - Each service location must be identified for coverage on the certificate.
- ☐ W-9 Form
- ☐ An explanation for every "Yes" response to the disclosure questions on the credentialing application, that includes the dates of each incident and status of each case
- ☐ Ownership and Disclosure Form (Government Programs requirement)
- ☐ Current Medicare Certification Letter or verification of your Medicare supplier number from the Center for Medicare & Medicaid Services (CMS), (if applicable)
- ☐ Medicaid enrollment number or written evidence of 21st Century Cures enrollment, **required if applying for Horizon NJ Health participation**
- ☐ Accreditation Certificate per service location **or** a copy of the full CMS or State audit report, plan of correction and Post-Certification Revisit Report, including the approval letter for non-accredited facilities
- ☐ Americans with Disabilities Act Provider Survey if the location is new and the survey has not been previously submitted (Government Programs requirement)
- ☐ CLIA Certificate of Waiver

PROVIDER INFORMATION

Legal Entity Name: _____

Provider DBA Name: _____

Specialty: _____

State of Incorporation: _____

Tax Identification #: _____ **(Provide a copy of your W-9)**

National Provider Identification Number (NPI) _____
Please provide a copy of the confirmation from CMS

If you have multiple NPI numbers or Taxonomy codes, please provide a separate attachment indicating each location and specialty, and applicable Taxonomy Code.

Is your organization certified by the following? If yes, please provide a copy of the certification letter.

Medicare:	☐ YES	☐ NO	Number: _____
Medicaid:	☐ YES	☐ NO	Number: _____
Other_____	☐ YES	☐ NO	Number: _____

Primary Address: _____
Phone #: _____
Fax # _____
Other Locations: _____
_____

Name of Executive Contact: _____
Title: _____
Telephone # _____
Mobile # _____
Fax # _____
E-mail address _____

Name of Contract Manager: _____
Title: _____
Telephone # _____
Mobile # _____
Fax # _____
E-mail address _____

Name of Credentialing Contact: _____
Title: _____
Telephone # _____
Mobile # _____
Fax # _____
E-mail address _____

Name of Clinical Contact: _____
Title: _____
Telephone # _____
Mobile # _____
Fax # _____
E-mail address _____

What is your service area (by county) in each state?

_____
_____
_____

AFFILIATED ORGANIZATION INFORMATION

Is your organization part of a larger organizational structure, (i.e. owned by a Hospital)?

☐ YES ☐ NO

If yes, please describe the structure.

_____
_____

Is the facility affiliated with any other healthcare provider?

☐ YES ☐ NO

If yes, please describe.

_____
_____

If you answered yes to the above question, are the facility's patients who need other levels of care ordinarily referred to the affiliated provider?

☐ YES ☐ NO

If yes, please describe.

_____

LICENSE/ACCREDITATION INFORMATION

Is the organization licensed by the state of New Jersey? ☐ YES ☐ NO

Please attach a copy of license, and the extension letter from the state of New Jersey if applicable.

If not licensed in the state of New Jersey, please indicate which state you are licensed in and attach a copy of your license: _____

Is your organization accredited? ☐ YES ☐ NO

a) If YES, by what accreditation organization:

☐ JCAHO ☐ CHAP ☐ CARF ☐ NCQA

☐ AAAHC ☐ HFAP ☐ COA ☐ NIAHO®

☐ ACHC ☐ Other _____

b) If NO, why not:

_____

GENERAL DISCLOSURE QUESTIONS

Please complete the required general disclosure questions below. Incomplete disclosures may result in delays in our credentialing process.

1. Does your organization have any pending, settled, dropped or dismissed liability cases?
   - ☐ Yes
   - ☐ No

   If you answered "Yes" above, please attach an explanation of each case which should include the date(s) of each incident and the final outcome.

2. Has your organization (or any owner controlling 10 percent or more of your organization) ever been subjected to or is currently undergoing any of the following:

   Government disciplinary action such as, but not limited to revocation of license or Medicare/Medicaid provider status?
   - ☐ Yes
   - ☐ No

   Medicare and/or Medicaid sanction within the last five years?
   - ☐ Yes
   - ☐ No

   Criminal or ethical investigation or conviction?

☐ Yes
☐ No

Bankruptcy, insolvency or assignment for the benefit or creditor proceedings?

☐ Yes
☐ No

Received any member complaints in the past 12 months?

☐ Yes
☐ No

If you answered "Yes" above, please attach an explanation of each case which should include the date(s) of each incident and the final outcome.

FACILITY SERVICE LOCATION ADDENDUM

INSTRUCTIONS: COMPLETE ONE FORM PER SERVICE LOCATION,
PLEASE INDICATE THE SERVICES CURRENTLY LICENSED

SERVICE LOCATION:

Address Line 1: _____

Address Line 2: _____

City, State, Zip: _____

Phone Number: _____

BILLING ADDRESS:

Address Line 1: _____

Address Line 2: _____

City, State, Zip _____

Phone Number: _____

Programs licensed at this location:	# of Bed (IP/Res)	Child (5-12)	Adol. (13-17)	Adults (18-64)	Geri (65+)	Telemedicine Available	Program Director Name & License	Facility Program License Number
Inpatient Psychiatric						N/A		
Inpatient (Acute) Detoxification						N/A		
Inpatient Substance Abuse Rehab						N/A		
Inpatient Dual Diagnosis						N/A		
Inpatient Eating Disorder						N/A		
Residential Detoxification						N/A		
Residential Treatment (Psych)						N/A		
Short Term Residential Treatment (Substance Abuse)						N/A		
Long Term Residential Treatment (Substance Abuse)						N/A		
Residential Treatment (Dual Diagnosis)						N/A		
Residential Treatment (Eating Disorder)						N/A		
Partial Hospitalization (Psych)	N/A							
Partial Hospitalization (Substance Abuse)	N/A							
Partial Hospitalization (Dual Diagnosis)	N/A							
Partial Hospitalization (Eating Disorder)	N/A							
23 Hour Observation	N/A							
Ambulatory Detoxification	N/A							
Intensive Outpatient (Psych)	N/A							

Programs licensed at this location:	# of Bed (IP/Res)	Child (5-12)	Adol. (13-17)	Adults (18-64)	Geri (65+)	Telemedicine Available	Program Director Name & License	Facility Program License Number
Intensive Outpatient (Substance Abuse)	N/A							
Intensive Outpatient (Dual Diagnosis)	N/A							
Intensive Outpatient (Eating Disorder)	N/A							
*Methadone Maintenance Therapy *Indicate # of days per week in # of units column*	N/A							
Medication Assisted Treatment (non methadone) *Suboxone: YES _____ NO _____* *Vivitrol: YES _____ NO _____* *Other: Please specify:* *_____*	N/A							
Adult Mental Health Rehab (AMHR)	N/A							
Home Health	N/A							
Outpatient Clinic (Psych)	N/A							
Outpatient (Substance Abuse)	N/A							
Outpatient (Dual diagnosis)	N/A							
ECT: *Inpatient: ___YES ___NO* *Outpatient: ___YES ____NO*	N/A							
Crisis Intervention/ER	N/A							
TMS	N/A							

Please describe any specialized programs or specialty tracks related to targeted patient populations and/or conditions (i.e. First Responder programs, Eating Disorders, etc.)

_____

_____

_____

Affirmation of Information

All information submitted by me on behalf of _____ an ancillary provider (the "provider") is true and correct to the best of my knowledge and belief. I understand that as an authorized representative of the provider, I have the right to review the information submitted in support of the provider's application. I understand that if any of this information is subsequently found to be false, misleading or incomplete, it could result in denial of the provider's application or termination of participation in the Horizon Blue Cross Blue Shield of New Jersey provider network, or any of its subsidiary or affiliate provider networks (hereafter collectively referred to as "Horizon BCBSNJ").

I understand and agree that I have the responsibility for producing adequate and accurate information for proper evaluation of the qualifications of the provider and for resolving any doubts about such qualifications. I also agree to provide information on an ongoing basis as requested and in accordance with any specific future request that is relevant to Horizon BCBSNJ's evaluation of the provider's application, credentials or qualifications, and that this statement in its entirety shall also apply then.

I hereby authorize and consent to Horizon BCBSNJ's acquisition of information from any person or organization, as long as such acquisition is done in good faith and without malice in connection with Horizon BCBSNJ's evaluation of the provider's application, credentials and qualifications.

I hereby release from liability Horizon BCBSNJ, its agents or designees, and any and all persons or organizations that provide information to Horizon BCBSNJ, its agents or designees, for any and all actions taken in good faith and without malice in connection with Horizon BCBSNJ's review of the provider's application, credentials and qualifications.

I attest that to the best of my knowledge the information provided in response to the questions on the Ancillary Behavioral Health Credentialing Application have been answered correctly.

Name _____

Title_____

Entity Name _____

Signature _____

Date _____

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