BCBSM Mental Health and Substance Abuse Managed Care Networks

Blue Cross Blue Shield of Michigan

Credentialing Application for Professional Providers

Instructions

1. Enter information on-line. **Press the "Tab" key to move from one field to another.** After completion, print, sign and date documents.
2. Please include copies of the following:
   - State license or registration
   - Proof of Liability Insurance
   - Graduate Program Certification
   - Certification
3. Mail application and all attachments to:

Attn: Professional Credentialing Department, MC B444
Blue Cross Blue Shield of Michigan
600 E. Lafayette Blvd.
Detroit, Michigan 48226-2998

If you have any questions regarding the credentialing application, please call 1-800-985-7434.

Please identify yourself as one of the following:

☐ **LMSW Licensed Master's Social Worker** ☐ **Clinical Nurse Specialist**

1. Last Name _____

2. First Name _____

3. Your Degree _____

4. Birthday _____

5. Primary Address (Where majority of patients are treated)

   a. Street Address _____

   b. City _____ c. State _____

   d. Zip Code _____ e. County _____

   f. Area Code and Telephone Number _____ g. Fax _____

   h. Contact Person _____

6. Secondary Office(s) Address (Attach list if necessary)

   a. Street Address _____

   b. City _____ c. State _____

   d. Zip Code _____ e. County _____

   f. Area Code and Telephone Number _____ g. Fax _____

   h. Contact Person _____

7. Are you currently accepting new patients? ☐ Yes ☐ No

8. Report your BCBSM Provider Identification Number (if available) _____

9. a. Federal Tax ID Number _____

   b. Social Security Number _____

10. State License/ Registration Number (attach copy) _____

    a. First Date of Issue _____

    b. Current License Expiration Date _____

11. Identify your specialty (if applicable) _____

12. Your subspecialty (if applicable) _____

13. Professional Liability Insurance - Minimum requirement is $1,000,000 per occurrence and $3,000,000 aggregate (Attach copy of face sheet that includes the carrier, policy number, your name as insured, coverage amounts and effective dates for each policy).

    a. Is your malpractice insurance coverage equal to or greater than $1,000,000 per occurrence and $3,000,000 aggregate? ☐ Yes ☐ No

    b. Does your professional liability insurance cover you in all your practicing locations? ☐ Yes ☐ No

    c. Have you had any malpractice suits filed/settled against you within five years of this application? ☐ Yes ☐ No

    (If yes, complete, sign and date the attached Malpractice Lawsuit Information Form for each case. Make additional copies of the form if necessary).

    Current insurance carrier name _____

    Address _____

    City _____ State _____ Zip Code _____

    Coverage Limits
    Per Occurrence _____ Per Year _____ Coverage Expiration Date _____

14. Has your license to practice in any jurisdiction ever been

Denied	☐ Yes	☐ No	Revoked	☐ Yes	☐ No
Restricted	☐ Yes	☐ No	Placed on Probation	☐ Yes	☐ No
Limited	☐ Yes	☐ No	Reprimanded by a Licensing Agency	☐ Yes	☐ No
Suspended	☐ Yes	☐ No			

    If you answered yes to any of the above, please provide a detailed explanation and attach.

15. Have you ever been convicted of a felony? ☐ Yes ☐ No

    Have you ever been convicted of a misdemeanor? ☐ Yes ☐ No

    If yes, what action(s) occurred, when and in what state(s)?

16. Have you been expelled or suspended from receiving payment from Medicare or Medicaid or any other insurance carrier? ☐ Yes ☐ No

17. Do you have provisions in place for emergency treatment of patients? ☐ Yes ☐ No

18. Does your office have access for the physically challenged? ☐ Yes ☐ No

19. Check all areas in which you have specialized formal training

- ☐ Brief or focused therapy
- ☐ Psychological testing
- ☐ Group therapy
- ☐ Psychoanalysis
- ☐ Behavior modification therapy
- ☐ Chemical dependency
- ☐ Other (please specify)_____
- ☐ Family therapy
- ☐ Neuropsychological testing
- ☐ Social work assessment
- ☐ Family assessment
- ☐ Behavior modification therapy
- ☐ Occupational/Recreational assessment

20. Check the following specialized areas in which you have specialized expertise.

a. Specialty areas:

- ☐ Children
- ☐ Adolescent
- ☐ Adult
- ☐ Geriatric
- ☐ Male
- ☐ Female

b. Cultural groups (specify) _____

c. Foreign language (specify) _____

d. American Sign Language ☐ Yes ☐ No

e. Primary specialty areas (Check no more than five)

- ☐ Substance abuse
- ☐ Affective disorders
- ☐ Schizophrenia
- ☐ Developmental disorders
- ☐ Learning disabilities
- ☐ Conduct disorders
- ☐ Attention deficit disorders
- ☐ Organic mental disorders
- ☐ Sexual abuse
- ☐ Eating disorders
- ☐ Anxiety disorders
- ☐ Phobias
- ☐ Personality disorders
- ☐ AIDS Patients
- ☐ Physical Abuse/Neglect
- ☐ Paranoid disorders
- ☐ Disorders of childhood & adolescence
- ☐ Dissociative/multiple
- ☐ Adjustment disorders
- ☐ Primary substance abuse problems
- ☐ Primary marriage/family problems
- ☐ Dementia/neuropsychiatric disorders
- ☐ Mental retardation
- ☐ Sexual identity orientation
- ☐ Impulse disorders
- ☐ EAP functions
- ☐ Post traumatic stress disorders
- ☐ Chronic pain disorders
- ☐ Chronic mental illness
- ☐ Other_____

21. LMSW Licensed Master's Social Worker

a. Indicate current certification. (Please include current copy):

- ☐ Academy of Certified Social Workers (ACSW)
- ☐ Diplomate status in clinical social work by the American Board of Examiners in Clinical Social Work (ABECSW)
- ☐ Diplomate status in clinical social work by the National Association of Social Workers (NASW)
- ☐ Not currently certified in any of the above

b. Do you have 5 years of post Masters Clinical Social Work experience (at least 2 of which were supervised by an ACSW/Diplomate)? ☐ Yes ☐ No

c. Please provide name and location of your graduate program and date of graduation (Please include copy)

22. Clinical Nurse Specialist

a. Indicate your American Nurse Association (ANA) specialty certification. (Please include current copy)

☐ Clinical Specialist in Adult Psychiatric and Mental Health Nursing
☐ Clinical Specialist in Child and Adolescent Psychiatric and Mental Health Nursing
☐ Not currently certified in any of the above

b. Do you have 5 years post Masters degree experience in the field of psychiatric/mental health nursing?
☐ Yes ☐ No

c. Please provide name and location of your graduate program and date of graduation

d. Have you ever had treating privileges revoked, suspended or limited at any hospitals? (If yes, please include a copy of order) ☐ Yes ☐ No

23. Crisis Evaluation/Intervention Services

Indicate your 24-hour on-call availability:

a. Do you have 24-hour availability for your patients? ☐ Yes ☐ No
b. Do you use an answering service and/or pager? ☐ Yes ☐ No
c. Do you have a psychiatrist on call for your practice and emergency clinical situations? ☐ Yes ☐ No

Psychiatrist name _____ Phone number _____

24. Substance Abuse Services

Indicate the services you provide:

☐ a. Alcohol treatment ☐ b. Drug treatment
☐ c. Polysubstance treatment ☐ d. Dual diagnosis (psych/substance abuse)

List your qualifications to treat chemical dependency indicating specific education, training, and certification. (Attach list as needed)

25. Chronic Mental Illness

Do you provide services for chronic mental illness? ☐ Yes ☐ No

Name of person completing application

Title _____ Phone Number _____

I hereby certify that all of the responses and information provided to the above questions and requests are complete, true and correct to the best of my knowledge and belief.

I also verify that I am able to perform all of the procedures or services specified in my contract and/or credentialing application with or without reasonable accommodation, according to accepted standards of professional performance for that medical or health care specialty without posing a direct threat to patients. (If there are reasons for any inability to perform the essential functions of the position, with or without accommodation, please explain on an additional sheet and attach).

Signature of applicant _____ Date _____

Print name _____

Include the following documents and mail to the address listed below

- Completed and signed application
- Signed Participation Agreement Signature Document
- State license or registration
- Signed Addendum A
- Signed Authorization for Release of Information form
- Malpactice Lawsuit Information form (If you answer "yes" to question 13c)
- Proof of Liability Insurance
- Graduate Program Certificate
- Certification

Attn: Professional Credentialing Department, MC B444
Blue Cross Blue Shield of Michigan
600 E. Lafayette Blvd.
Detroit, Michigan 48226-2998

Authorization for Release of Information

The undersigned provider hereby authorizes Blue Cross Blue Shield of Michigan, solely in conjunction with activities in the administration of the Mental Health and Substance Abuse Managed Care Networks, to contact and obtain information from one or more of the following organizations:

- State/National/Local Psychiatric, Psychological, and Mental Health Association(s) and their communities (e.g., ethics committees).
- Appropriate County Societies in those areas where the provider resides and practices.
- State/National/Local Board(s) and/or accrediting bodies responsible for professional licensing, regulation and certification.
- Any other organization deemed appropriate to contact in order to complete the provider selection process for this program.

I authorize the release of information regarding myself and my practice from these organizations solely for the purpose of permitting inquiry into the appropriateness of my selection for and continued participation in the Mental Health and Substance Abuse Managed Care Networks.

Print Name _____

Signature of Applicant _____ Date _____

In addition to the information requested on the application, please answer the following questions about your work history and health status.

Work History

1. In chronological order, please state all work history for the past five years. This information must be completed.

Date	Primary Practice/Location
From _____ to Present	
From _____ to _____	
From _____ to _____	
From to	

2. Explain any gaps in the work history exceeding 6 months: (If additional space is required, please attach an additional page)

Health Status

Answer the following three questions by checking Yes or No

1. Are you presently using any chemical substance(s) that may in any way impair or restrict your ability to practice medicine with reasonable skill and safety? ☐ Yes ☐ No
2. Do you currently engage in the illegal use of controlled substances? ☐ Yes ☐ No
3. Do you have a mental or physical condition that in any way may impair or limit your ability to practice medicine with reasonable skill and safety with or without accommodation? ☐ Yes ☐ No

Addendum A is part of your application to BCBSM for affiliation/reaffiliation with the Mental Health and Substance Abuse Managed Care Networks. As such, the verification of the BCBSM State of Michigan Mental Health and Substance Abuse Managed Care Networks application, and the consent and release at the top of the Authorization for Release form apply to your responses to the questions asked in this Addendum.

Signature of applicant _____ Date _____

Print name _____

Blue Cross Blue Shield of Michigan

Malpractice Lawsuit Information Form

If you answer yes to Question 13c you must complete this form.

1. Name of Case _____
2. Case Number _____
3. Name of the Court in which the case was filed _____
4. Date of the Occurrence about which plaintiff complained _____
5. Date on which the lawsuit was filed _____
6. Summary Detail of Case: Claims history from the carrier is not acceptable. Please provide a detailed description of the plaintiff's allegation and the defendant's answer to those allegations. **Also, include a page from the patient's record that substantiates the service(s), if available. Attach copies to this form. If not available then provide a detailed explanation below.**

Continue Summary

Blue Cross Blue Shield of Michigan

Summary Detail of Case (Continued)

7. Is this case (Check one) ☐ closed ☐ pending
8. If closed, was it by (Check one) ☐ settlement ☐ verdict
9. State the amount of the settlement or verdict against you _____
10. If you know, state the amount of the settlement by or verdict against parties other than yourself
11. Name and address of your insurance carrier in this case

Print Name _____

Signature of Applicant _____ Date _____