Coos Health & Wellness

Together, Inspiring Healthier Communities

Reset Form

INDIVIDUAL PROVIDER CREDENTIALING/RECREDENTIALING APPLICATION

Name (Last, First, Middle)

Date of Birth Social Security Number

Business Name

Office Address City State Zip Code

Office Phone Office Fax Email

Office Hours:

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

Billing Contact Billing Contact Phone

Billing Address (*if different from office address)* City State Zip Code

Federal Tax ID: _____

DMAP # _____

National Provider Indentifier (NPI) _____

Primary Taxonomy # _____

1975 McPherson Avenue, Ste 2, North Bend, OR 97459
541-751-2500
Crisis Line-751-2550

Customary Charges	Dollar Amount
Assessment (90791, 90792)	
Evaluation and Mgmt Services (99201-05, 99211-15)	
Individual (90832, 90834, 90837)	
Family Therapy (90846 and 90847)	
Group Therapy (90853)	
Case Management (per 15 minutes)	
Skills Training (per 15 minutes)	
Other:	

PRACTICE TREATMENT INFORMATION

Age Categories:

☐ Geriatrics (65 and older) ☐ Adult (18–64) ☐ Adolescent (13– 17)
☐ Older Child (6 – 12) ☐ Younger Child (0 – 5)

Specific Categories:

☐ Group Therapy ☐ Anger Issues HIV/AIDS
☐ ☐ Borderline Personality
☐ Trauma ☐ Domestic Violence
☐ Developmental Disorders ☐ Faith-Based Counseling
☐ Medical Co-Morbidity ☐ Sex Offender Treatment
☐ Psychological Testing ☐ Medication Management
☐ Sexual Disorders ☐ Eating Disorders
☐ Gay/Lesbian Issues ☐ Marriage/Family
☐ Co-occurring Disorders ☐ Fire Setting Evaluation
☐ Other_____

Languages Spoken by Provider and Staff:

_____
Provider

_____
Staff

Please describe your 24-hour or crisis coverage:

_____

_____

_____

Does your office space meet the ADA Accessibility Standards?
☐ Yes ☐ No ***(please describe)***

_____

_____

Type of Practice:

☐ Solo ☐ Single Specialty Group
☐ Multi-Specialty Group ☐ Other:_____

Do you currently have Medicare Certification? ☐ Yes ☐ No

Treatment Philosophy/Strategies Utilized:

_____

_____

_____

_____

Please describe how clinical supervision is obtained:

_____

_____

_____

_____

LICENSURE AND CERTIFICATIONS

Please mark the following license(s) that you carry in the State of Oregon:

☐ Licensed Clinical Social Worker License #
☐ Licensed Marriage and Family Therapist License #
☐ Licensed Professional Counselor License #
☐ Registered Nurse License #
☐ Medical Doctor License #
☐ Licensed Psychologist License #
☐ Psychiatric Nurse Practitioner License #
☐ CADC License #
☐ Other – please describe below

Please list other licenses, credentials or certificates (e.g. board certifications, licenses in other states):

Please list any professional affiliations/memberships (e.g. NASW, APA):

Have you ever worked in a public agency in which you have been deemed a Qualified Mental Health Professional (QMHP)? ☐ Yes ☐ No

PROFESSIONAL LIABILITY INSURANCE

Current Insurance Carrier Phone

Address City State Zip Code

Policy Number Coverage Dates

Policy Type Coverage Amount Per Occurrence

Policy Expiration Date

PROFESSIONAL REFERENCES

(Please list three peers who have direct knowledge of your clinical abilities. Do not include family members.)

Name Phone:

Address City State Zip Code

Name Phone:

Address City State Zip Code

Name Phone:

Address City State Zip Code

ADDITIONAL QUESTIONS

(Please answer the following questions. If you answer Yes to any question, please use a separate sheet of paper to provide an explanation.)

	Yes	No	Not Applicable
Has your license ever been limited, restricted, suspended, revoked or voluntarily surrendered, denied or not renewed, or are any of these actions pending with respect to your license?	☐	☐	☐
Have you ever been reprimanded by a state licensing agency or are you under investigation by any licensing or regulatory agency?	☐	☐	☐
Have you or your agency ever been sanctioned by Medicare or Medicaid?	☐	☐	☐
In the past seven years have you been convicted of a felony or misdemeanor or are you under investigation with respect to such conduct?	☐	☐	☐
Have professional liability claims ever been assessed against you or are there any professional liability cases pending against you now?	☐	☐	☐
Have you ever had your liability insurance carrier cancel, refuse coverage or had rate increases because of an unusual risk?	☐	☐	☐

ADDITIONAL DOCUMENTATION

(Please attach copies of the following documents, if applicable):

☐ Resume or CV
☐ Current State Licenses
☐ Current Federal DEA Registration
☐ Board Certification Certificates
☐ Proof of Current Professional Liability Insurance
☐ Official Transcripts *(Transcripts only need to be provided if you currently <u>do not</u> have a state issued license to practice medicine, mental health or chemical dependency treatment.)*

CERTIFICATION OF INFORMATION

By signing the below I certify that:

- The information provided is true and correct.
- If any of the information should change I will notify Coos County Mental Health within three (3) days of the change.
- I hereby give Coos County Mental Health permission to verify any and all credentialing information.
- I understand that this credentialing review does not grant me participation as a network provider for Coos County Mental Health. I am only able to see Oregon Health Plan members that are specifically approved on a case-by-case basis by Coos County Mental Health.

_____

Signature Date