OPTIMA BEHAVIORAL HEALTH

CMHRS APPLICATION PACKET

Thank you for your interest in becoming a participating provider with Sentara Health Plans, dba Optima Behavioral Health (OBH). We are currently accepting applications for Community Mental Health Rehabilitative Services (CMHRS) organizations.

Any provider requesting participation with OBH seeking to offer services for Commonwealth Coordinated Care Plus members, must go through this process. This can include providers already participating in other products.

Please submit the following documents to OBH Network Management:

Via email to: OrgProviderApp@sentara.com
Or via Fax to: 1-866-751-7645

- Completed OBH CMHRS Application
- Completed and current W-9
- Clinical Staff Roster *(must include last name, first name, DOB, NPI – if applicable, and services provided)*
- Copy of DBHDS License and Licensed Services Addendum*
- Copy of all other Licensure, Accreditations, and/or Certifications held by the organization
- Copy of Professional Liability Certificate of Insurance *(Face Sheet)*
- Additional Locations Forms *(if applicable)*

** Each service/location that you submit on the application will be verified per the DBHDS Licensure addendum.*
** Behavioral Therapy services will be approved for the Organization, but you must also complete a Behavioral Health Provider Credentialing Packet for each ABA practitioner. The packet is available on our website.*

Please note, the process to complete your application and set-up in our network can take approximately 90-120 days from receipt of all required information. We will notify you with any questions or once this is complete. If you have questions about the requested information or process, please call 757-687-6333.

Sincerely,
Optima Behavioral Health
Network Management

Enclosures

OptimaHealth

OPTIMA BEHAVIORAL HEALTH
CMHRS APPLICATION

Please print or type and complete all sections of this application.

CMHRS ORGANIZATION INFORMATION

Legal Business Name: _____

DBA Name: _____
(if different from legal name)

Federal Tax ID #: _____

URL (Website) Address: _____

Administrator Name/Title: _____

Phone: _____

Email: _____

CREDENTIALING CONTACT INFORMATION

Credentialing Contact Person Name: _____

Email: _____

Phone: _____

Fax: _____

SERVICE LOCATION – Primary Location

PRIMARY LOCATION:

DBA Name (if different from legal name): _____

Primary Street Address: _____
(Cannot be a PO Box)

Room/Suite/Floor: _____

City: _____ State: _____ Zip: _____

Office Email: _____ Phone: _____ Fax: _____

Group/Type 2 NPI #: _____ Medicare #: _____ Medicaid #: _____

Office Manager Name: _____

Office Hours for this location:

	Start	End		Start	End
Monday			Friday		
Tuesday			Saturday		
Wednesday			Sunday		
Thursday					

Office Accessibility for this location:

☐ Wheelchair Accessible ☐ Public Transportation within one mile

Languages Spoken in this office:

☐ English	☐ Vietnamese	☐ Portuguese	☐ Yupik
☐ Spanish	☐ Korean	☐ Italian	☐ Polish
☐ German	☐ Navajo	☐ Arabic	☐ French Creole
☐ French	☐ Tagalog	☐ Dakota	☐ Other: _____

If you provide home-based services, please list all counties that you serve:

SERVICE LOCATION – Location 2

LOCATION 2:

DBA Name (if different from legal name): _____

Street Address: _____
(Cannot be a PO Box)

Room/Suite/Floor: _____

City: _____ State: _____ Zip: _____

Office Email: _____ Phone: _____ Fax: _____

Group/Type 2 NPI #: _____

Office Manager Name: _____

Office Hours for this location:

	Start	End		Start	End
Monday			Friday		
Tuesday			Saturday		
Wednesday			Sunday		
Thursday					

Office Accessibility for this location:

☐ Wheelchair Accessible ☐ Public Transportation within one mile

Languages Spoken in this location:

☐ English	☐ Vietnamese	☐ Portuguese	☐ Yupik
☐ Spanish	☐ Korean	☐ Italian	☐ Polish
☐ German	☐ Navajo	☐ Arabic	☐ French Creole
☐ French	☐ Tagalog	☐ Dakota	☐ Other: _____

SERVICE LOCATION – Location 3

LOCATION 3:

DBA Name (if different from legal name): _____

Street Address: _____
(Cannot be a PO Box)

Room/Suite/Floor: _____

City: _____ State: _____ Zip: _____

Office Email: _____ Phone: _____ Fax: _____

Group/Type 2 NPI #: _____

Office Manager Name: _____

Office Hours for this location:

	Start	End		Start	End
Monday			Friday		
Tuesday			Saturday		
Wednesday			Sunday		
Thursday					

Office Accessibility for this location:

☐ Wheelchair Accessible ☐ Public Transportation within one mile

Languages Spoken in this location:

☐ English	☐ Vietnamese	☐ Portuguese	☐ Yupik
☐ Spanish	☐ Korean	☐ Italian	☐ Polish
☐ German	☐ Navajo	☐ Arabic	☐ French Creole
☐ French	☐ Tagalog	☐ Dakota	☐ Other: _____

If you have more than 3 service locations, please complete an Additional Location Form for each location and attach/return with this application. The form is available on our website.

CMHRS SERVICE TYPES

Please complete this table for all CMHRS services that your organization provides.
Please be sure to submit all required licenses for these services.
Submit Additional Locations Forms, as needed, for more than 3 locations.

Do you Provide this Service?	Service Procedure Code	CMHRS Service Name	For all services you provide, please check the locations where they are offered.
☐ Yes ☐ No	H0023	Mental Health Case Management *(CSB member/Behavioral Health Authority (BHA) and licensed by DBHDS to provide case management)*	☐ Primary ☐ 2 ☐ 3
☐ Yes ☐ No	H0035 HA	Therapeutic Day Treatment (TDT) School Day, Child *(DBHDS license to provide Day Treatment Services)*	☐ Primary ☐ 2 ☐ 3
☐ Yes ☐ No	H0035 HA & UG	TDT Afterschool, Child	☐ Primary ☐ 2 ☐ 3
☐ Yes ☐ No	H0035 HA & U7	TDT Summer Program Child	☐ Primary ☐ 2 ☐ 3
☐ Yes ☐ No	H0032 U7	TDT Assessment, Child	☐ Primary ☐ 2 ☐ 3
☐ Yes ☐ No	H0035 HB	Day Treatment/Partial Hospitalization, Adult *(DBHDS license to provide Day Treatment Services)*	☐ Primary ☐ 2 ☐ 3
☐ Yes ☐ No	H0032 U7	Day Treatment/Partial Hospitalization Assessment, Adult	☐ Primary ☐ 2 ☐ 3
☐ Yes ☐ No	H0036	Crisis Intervention *(DBHDS license in Emergency Services/Crisis Intervention and Outpatient services.)*	☐ Primary ☐ 2 ☐ 3
☐ Yes ☐ No	H0039	Intensive Community Treatment (ICT) *(DBHDS license to provide Intensive Community Treatment (ICT) or Program of Assertive Community Treatment (PACT))*	☐ Primary ☐ 2 ☐ 3
☐ Yes ☐ No	H0032 U9	ICT Assessment	☐ Primary ☐ 2 ☐ 3
☐ Yes ☐ No	H0046	Mental Health Skill-building Services (MHSS) *(DBHDS license as a provider of Supportive In-Home Services, Intensive Community Treatment (ICT) or Program of Assertive Community Treatment (PACT))*	☐ Primary ☐ 2 ☐ 3
☐ Yes ☐ No	H0032 U8	MHSS Assessment	☐ Primary ☐ 2 ☐ 3
☐ Yes ☐ No	H2012	Intensive In-Home (IIH) *(DBHDS license in Intensive In-Home Services)*	☐ Primary ☐ 2 ☐ 3
☐ Yes ☐ No	H0031	IIH Assessment	☐ Primary ☐ 2 ☐ 3
☐ Yes ☐ No	H2017	Psychosocial Rehab *(DBHDS license to provide Psychosocial Rehab or Clubhouse Services)*	☐ Primary ☐ 2 ☐ 3
☐ Yes ☐ No	H0032 U6	Psychosocial Rehab Assessment	☐ Primary ☐ 2 ☐ 3
☐ Yes ☐ No	H2019	Crisis Stabilization *(DBHDS license to provide Mental Health Crisis Stabilization and Outpatient Services)*	☐ Primary ☐ 2 ☐ 3
☐ Yes ☐ No	H2033	Behavioral Therapy*	☐ Primary ☐ 2 ☐ 3
☐ Yes ☐ No	H0032 UA	Behavioral Therapy Assessment*	☐ Primary ☐ 2 ☐ 3
☐ Yes ☐ No	H0024	Peer Support Services, Individual Mental Health	☐ Primary ☐ 2 ☐ 3
☐ Yes ☐ No	H0025	Peer Support Services, Group Mental Health	☐ Primary ☐ 2 ☐ 3
☐ Yes ☐ No	T1012	Peer Support Services, Individual Substance Use Disorder	☐ Primary ☐ 2 ☐ 3
☐ Yes ☐ No	S9445	Peer Support Services, Group Substance Use Disorder	☐ Primary ☐ 2 ☐ 3

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