OptimaHealth

4417 Corporation Lane
Virginia Beach, VA 23462

4/1/2020

COVID-19 Application Short Form

☐ Yes ■ No Is this application being submitted to assist with the emergent healthcare needs due to COVID-19?

If no, please complete the following application as usual.

If yes, please complete the questions below, but still complete and submit the following application and checklist requirements.

Check those that apply:

☐ Returning retiree
☐ Early Graduate (with VA license)
☐ Out of State License
☐ Other: _____

Provide your primary work location:

_____

_____

_____

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Optima Behavioral Health
New Provider Application Packet

Thank you for your interest in becoming a participating provider in the Optima Behavioral Health (OBH) Network. We are currently accepting applications from licensed behavioral health providers and board certified MDs. Please review the following instructions to ensure acceptance of your application.

1. **Visit www.CAQH.org to complete an application. Optima Health uses the online Council for Affordable Quality Healthcare (CAQH) application exclusively for all Providers. We require that all of your information be entered and accurate in CAQH. We will be unable to accept your application until it is complete.**
   Please contact the CAQH Provider Help Desk (1-888-599-1771 or providerhelp@ProView.CAQH.org) for assistance with the CAQH application.

2. **Once your CAQH application is complete (with all required attachments), please complete and return all required information on the checklist to Network Management:**

   Via email to: **BHCredentialing@Sentara.com**
   Or via Fax to: **1-866-751-7645**

3. **Once we receive a completed application and all required paperwork:**

   a. **Your paperwork will be forwarded to the Optima Health Credentialing Department** for review, verification, and presentation to the Medical Director and Credentialing Committee for final determination. **The credentialing process typically takes between 60-90 days upon receipt of a complete and accurate application.**

   b. **If required, we will send a contract for your review and signature. Please return as soon as possible.** OBH cannot move forward with the review of your application until your signed contract is received. (Note: If you are part of a practice that has a group contract already in place with OBH, we will not send you a contract at this time. Please check with your practice owner/manager for this information.)

4. Upon approval by the Optima Health Credentialing Committee, you will be notified by your assigned Network Educator of your Optima Health participation effective date. **Providers should not begin scheduling or treating Optima Health members on an in-network basis until they are notified of their Optima Health effective date.**

If you have any questions about the requested information or about the application, credentialing process, or status, please contact Provider Services at 1-800-648-8420 or BHCredentialing@sentara.com. We look forward to working with you.

Sincerely,
Optima Behavioral Health
Network Management

Enclosures

OptimaHealth

BEHAVIORAL HEALTH NEW PROVIDER CHECKLIST

This list is provided to assist you through the application process.

CAQH

We require that all of your information be entered and accurate in CAQH. We will be unable to accept your application until it is complete. (For assistance with attaching documents within CAQH, contact their provider help desk at 1-888-599-1771.)

This includes, but may not be limited to, the following:

- Your Personal Information and Professional IDs
- All state license(s) information
- NPI number
- Ten years of work history listed in month/year format
- All practices and locations at which you will be routinely providing services to OBH members
- Current W-9 for each practice (attached to your CAQH application)
- Partners and Associates or Covering Colleagues *(List any participating OBH partners/associates within your practice or a colleague outside of your practice who will cover for you in the event of your absence.)*
- Professional Liability Insurance (attached to your CAQH application)
    - For Virginia prescribing* licensees: limits must be at least equal to the current year VA state cap requirements (http://law.lis.virginia.gov/vacode/title8.01/chapter21.1/sections8.01-581.15/) (*Note: if your license affords you the ability to write prescriptions, you must meet these limits regardless of your prescribing habits.)
    - For non-Virginia licensees and non-prescribing practitioners: limits must at least equal $1 million/$3 million

REQUIRED ATTACHMENTS

In addition to completing your CAQH, please be sure to send us all of the following required forms/documents:

- Provider Information Form
- Member Matching Information Form
- Authorization and Release Form – dated no older than 60 days from the current date
- Cross Coverage Form
- Copies of all applicable licenses, certifications, approvals
- Resume with five (5) years of experience listed in month/year format (if not included in your CAQH Work History)

Network Management will forward your application and paperwork to the Optima Health Provider Credentialing Department. A credentialing analyst will reach out to you to request any other required information, which may include:

- Two (2) years of liability insurance history; Seven (7) years for MDs
- Any gaps in liability history are explained – notated in CAQH
- Gaps in work history greater than 6 months are explained – notated in CAQH
- Two professional references (NC, MD, TN, WV applicants must provide an attachment with name, address, fax, phone for each reference.)
- Explanation for any "yes" answers to disclosure questions
- Board Certificate (if applicable)
- DEA Registration Certificate (if applicable)
- ECFMG (if applicable)

You may contact the Optima Behavioral Health Credentialing Team via email at BHCredentialing@sentara.com.

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BEHAVIORAL HEALTH PROVIDER INFORMATION FORM

(all fields are required)

Provider Name_____ License Type_____

Individual NPI#_____ Taxonomy_____

CAQH#_____ Provider Email_____

Please indicate if you are licensed for any of the following:

☐ YES ☐ NO	**IOP**	If yes, include a copy of the group's DBDHS License
☐ YES ☐ NO	**OTP**	If yes, include a copy of the group's DBDHS License
☐ YES ☐ NO	**OBOT**	If yes, include a copy of the group's Certification/Approval from DMAS

Are you a participating Medicare provider?

☐ YES ☐ NO ☐ In process/Pending If yes, provide your Individual Medicare #:_____

Please check all products/networks that you are interested in applying to participate in.

☐ Commercial
☐ Medicaid – Optima Family Care (Medallion)
☐ Medicaid – Optima Health Community Care (CCC+)
☐ Medicare – Advantage plan (offered only in defined service area)
☐ Medicare – Dual Special Needs Plan (DSNP)
☐ EAP

NOTE: If we have any questions about the information in this packet, we will reach out to the provider listed above. If you would prefer that we contact someone else, please provide their information here:

Full Name _____

Phone # _____

Email Address _____

PRIMARY PRACTICE INFORMATION

Practice Name_____ Tax ID#_____

Practice NPI#_____ Practice Admin Email_____

Practice Address_____

Phone#_____ Fax#_____ Is this a confidential fax line? ☐ YES ☐ NO

Office Hours

Monday_____ Tuesday_____ Wednesday_____ Thursday_____

Friday_____ Saturday_____ Sunday_____

ADDITIONAL OFFICE LOCATION / PRACTICE INFORMATION

(Attach additional pages as necessary for more than two practices/locations)

☐ Additional Office Location
☐ Additional Practice

Practice Name_____ Tax ID#_____

Practice NPI#_____ Practice Admin Email_____

Practice Address_____

Phone#_____ Fax#_____ Is this a confidential fax line? ☐ YES ☐ NO

Office Hours

Monday_____ Tuesday_____ Wednesday_____ Thursday_____

Friday_____ Saturday_____ Sunday_____

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BEHAVIORAL HEALTH – MEMBER MATCHING INFORMATION FORM

This information will appear on your provider profile on optimahealth.com. Please complete entirely; any omitted information will be blank on the website and may exclude you from a member's "Find a Provider" search.

Provider Name_____

Individual NPI#_____

1. **Office Hours**: These hours should be inclusive of your availability at all locations you may have with this practice tax ID.

	Start	End		Start	End
Monday			Friday		
Tuesday			Saturday		
Wednesday			Sunday		
Thursday					

2. **Office Accessibility**

☐ Wheelchair Accessible ☐ Use of TDD ☐ Public Transportation within one block

3. **Populations Seen**

☐ Younger Children (0-5 years)
☐ Older Children (6-12 years)
☐ Adolescents (13-18 years)
☐ Adults
☐ Men
☐ Women
☐ Families
☐ Couples
☐ Geriatric
☐ Step Families
☐ Gay / Lesbian
☐ Inpatient
☐ Korean
☐ Hispanic
☐ Vietnamese
☐ Philippine
☐ Child/Adolescent Training/Fellowship
☐ Child/Adolescent Board Certified MD

4. **Treatment Categories:** (Check all that apply)

☐ Addictions
☐ ADHD
☐ Anger Management
☐ Anxiety Disorders
☐ Autism Spectrum Disorders
☐ Bipolar Disorder
☐ Blind/Visually Impaired
☐ Christian Focus
☐ Chronic Pain
☐ Crisis Intervention
☐ Depression
☐ Development Disability
☐ Eating Disorders
☐ ECT-Inpatient
☐ ECT-Outpatient
☐ Family/Victim Violence
☐ Forensic Evaluation
☐ Grief
☐ Head Injury Patients
☐ Hearing Impaired
☐ HIV/AIDS
☐ Hypnosis
☐ Inpatient Treatment
☐ Intellectually Disabled
☐ Medication Management
☐ Mood Disorders
☐ Neuropsychological Testing
☐ Outpatient Treatment
☐ Phobias/Habit Disorders
☐ Physically Impaired
☐ Psychological Testing
☐ PTSD
☐ Separation/Divorce
☐ Sexual Disorders
☐ Sexual/Physical Abuse
☐ Substance Abuse
☐ Terminally Ill
☐ Therapy - Family
☐ Therapy - Group
☐ Therapy – Individual
☐ Therapy – Marital/Couple

5. **Languages**:

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

6. **Additional Provider Information**:

It is our experience that patients often express preferences for providers of a particular ethnic background or gender. Providing this information will include you in the search list for these categories on optimahealth.com.

Gender
☐ Male
☐ Female

Ethnicity
☐ African-American
☐ American Indian / Alaskan Native
☐ Asian
☐ Caucasian
☐ Hispanic
☐ Other: _____

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Authorization and Release Form

A. General Conditions of Application

In return for my application being considered and processed, I agree to be legally bound by the following terms and conditions:

1. I know that it is my responsibility to produce adequate information so that my application can be properly evaluated. In addition to the information provided in this application, I will provide Sentara Health Plans, Inc. (hereinafter referred to as "the applicable Sentara Affiliated Health Plan(s)") with any additional information that they or their respective representatives may request. Failure to provide any requested information will cause my application to be incomplete, so that it cannot be processed.
2. I will keep this application current by informing the Sentara Affiliated Health Plan(s) through the Optima Health Medical Director, of any changes in the information provided.
3. I will be available for interviews with regard to this application.
4. As applicable and appropriate, I will accept committee assignments and other reasonable duties and responsibilities assigned to me.
5. I will provide timely and continuous care for all my patients.
6. My participation with the applicable Sentara Affiliated Health Plans is dependent upon my continued demonstration of professional competence and cooperation and acceptable performance of all related responsibilities.
7. I have had an opportunity to read a copy of the contract of the applicable Sentara Affiliated Health Plan(s), and I specifically agree to abide by the policies, rules and regulations, and directives that are in force during the time I am appointed.
8. I will abide by the applicable Sentara Affiliated Health Plan(s)' Corporate Compliance Policy and any laws, regulations and standards of conduct applicable to my profession, participation in any federal health program, or activities at the applicable Sentara Affiliated Health Plan(s) and will report any known or suspected violation to the Optima Health Medical Director.
9. All information provided in or attached to this application is accurate and complete. I know that any misrepresentation, misstatement or omission from this application shall constitute cause to stop the processing of my application. If my misrepresentation, misstatement, or omission is discovered after I have been appointed, that discovery may be an automatic relinquishment of my appointment and clinical privileges. Neither situation entitles me to any of the hearing or appeal rights contained in the policies at the applicable Sentara Affiliated Health Plan(s).

B. Information Sharing, Release, and Immunity

1. I understand that the entities to which I am applying for provider status is affiliated with Sentara Healthcare. I also understand that my Confidential Peer Review Information includes information and/or documentation regarding my clinical competence and/or professional conduct that is obtained or produced as part of the credentialing, quality assessment, and/or peer review processes conducted by Sentara Health Plans, Inc., and/or the Sentara Affiliated Health Plan(s). Such sharing is solely for the purposes of credentialing and peer review.

2. The Sentara Affiliated Health Plan(s) at which I am granted, or seek, participation, and Sentara Health Plans, Inc. may release to one another, and to the Sentara Healthcare Medical Affairs Committee, Confidential Peer Review Information regarding my practice.
3. Confidential Peer Review Information that is released shall be used solely for credentialing and peer review purposes and all Confidential Peer Review Information will be handled in confidence, in accordance with the protections and privileges afforded to peer review information under state and/or federal law.
4. I accept the following conditions and intend to be legally bound by them:
    a) To the fullest extent permitted by law, I extend immunity to, release from any and all liability, and agree not to sue Sentara Healthcare, the Sentara Healthcare Medical Affairs Committee, Sentara Health Plans Inc., the Sentara Affiliated Health Plan(s) at which I am granted, or seek, participation, their respective representatives, or any third parties for any matter relating to appointment, reappointment and clinical privileges, and participation in the Sentara Affiliated Health Plan(s), or my qualifications for the same.
    b) I authorize Sentara Health Plans Inc., and the Sentara Affiliated Health Plan(s) at which I am granted, or seek, participation and their respective representatives to consult with any third party who may have information bearing on my professional qualifications, credentials, clinical competence, character, ability to perform safely and competently, ethics, behavior, or any other matter reasonably having a bearing on my qualifications for participation in the Sentara Affiliated Health Plan(s). This authorization includes the right to inspect or obtain communications, reports, records, recommendations or disclosures that may be relevant to such questions. I specifically authorize these third parties to release the information to Sentara Health Plans Inc., and the Sentara Affiliated Health Plan(s) at which I am granted, or seek, participation and their respective representatives upon request.
    c) I also authorize Sentara Health Plans Inc., and the Sentara Affiliated Health Plan(s) at which I am granted, or seek, participation and their respective representatives to release such information to other hospitals, health care facilities and managed care entities and their agents, who seek such information for the purpose of evaluating my qualifications pursuant to a request for appointment and clinical privileges and participating provider status or other credentialing matter.
    d) I agree that the hearing and appeal procedures set forth in the Sentara Affiliated Health Plan(s)' policies are my sole and exclusive remedy with respect to any professional review action taken at the Sentara Affiliated Health Plan(s).
5. In the event that the terms and conditions of this release conflict with the terms and conditions of the Coalition for Affordable Healthcare's (CAQH) release, the terms and conditions of this release shall control as they relate to Sentara Healthcare.

_____

Signature of Practitioner

_____

Printed or Typed Name of Practitioner

_____

Date

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Behavioral Health Cross Coverage Form

- This form is required, even if covering colleague is/are listed on your CAQH application.
- Please have a covering colleague **who participates with Optima Behavioral Health** complete this form in its entirety.
- Please note that all partners, associates and/or covering colleagues should also be listed in your CAQH application.

_____
Name of Covering Practitioner, must be participating with Optima Health

_____
Practice Name of Covering Practitioner

_____
Phone number where Covering Provider may be easily reached

This is to confirm that I, _____
Name of Covering Optima Health Practitioner

will cover any members in crisis for _____
Name of Applying Practitioner

in the event of her/his unavailability.

_____
Signature of Covering Optima Health Practitioner

_____
Date