PROSPECTIVE PROVIDER REQUEST FORM

FamilyCare Health

Please type or print legibly. Questions? Call 503-222-3205 and ask for Network Development. You may also e-mail us at NetworkDevt@familycareinc.org. Completed forms may be emailed to NetworkDevt@familycareinc.org or faxed to 503-488-3651. Completion of this form is not a guarantee of contracting.

PROSPECTIVE PROVIDER CONTACT INFORMATION

Date: _____ **Person Completing Form:** _____

Phone#: _____ **Fax #:** _____

e-mail: _____

CLINIC/ORGANIZATION DATA

Legal Business Name (LBN): _____

Doing Business As (DBA): _____

Federal Tax ID Number (TIN): _____ ____ **Organization NPI:** _____

Oregon Medicaid ID#: _____ **Medicare ID#:** _____

Primary Practice Contact Name: _____

Primary Contact Phone#: _____

Primary Contact e-mail: _____

Clinic Website: http:// _____

Prospective Provider Requests must be accompanied by a current, signed, and dated W9.

Pursuing a contract for which line(s) of business? ☐ **MEDICARE** ☐ **MEDICAID**

BILLING ADDRESS (FINANCIAL CORRESPONDENCE, INCLUDING CHECKS)

Address: _____

City: _____ **State:** _____ **ZIP:** _____

Phone#: _____ _____**Fax#:** _____

Billing Contact Name: _____ **Billing Contact e-mail:** _____

MAILING ADDRESS (FAMILYCARE CORRESPONDENCE, INCLUDING POLICY UPDATES)

☐ **Check if same as Billing Address**

Address: _____

City: _____ **State:** _____ **ZIP:** _____

CREDENTIALING ADDRESS (FAMILYCARE CREDENTIALING CORRESPONDENCE FOR ALL PROVIDERS ASSOCIATED WITH CONTRACT)

☐ **Check if same as Billing Address or** ☐ **Check if same as Mailing Address**

Address: _____

City: _____ **State:** _____ **ZIP:** _____

Phone#: _____ **Fax#:** _____

Credentialing Contact Name: _____ **Credentialing Contact e-mail:** _____

PROSPECTIVE PROVIDER

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FamilyCare Health

PRACTICE LOCATION(S) - PAGE 1 of 2
PLEASE DUPLICATE THESE SHEETS FOR ADDITIONAL OFFICE LOCATIONS AS NEEDED.

Clinic Name: _____

Address: _____

City: _____ _____ **State:** _____ **ZIP:** _____

Clinic Phone#: _____ **Clinic Fax#:** _____

Clinic Back Office Phone#: _____

Practice Location NPI (if applicable): _____

Office Manager Name: _____

Manager Phone#: _____ **Manager e-mail:** _____

Electronic Health Records (EHR) system: _____ _____

Office Hours

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

Do you provide 24hr coverage? ☐ YES ☐ NO

If NO, please explain how your patients obtain advice and after hour care:

_____

_____

Inpatient Coverage Plan (for those without admitting privileges) **Does Not Apply ☐**

A. Name of Admitting Physician/Practice/Clinic/Group: _____

Hospital Where Privileged: _____

B. Name of Admitting Physician/Practice/Clinic/Group: _____

Hospital Where Privileged: _____

C. Name of Admitting Physician/Practice/Clinic/Group: _____

Hospital Where Privileged: _____

Covering Practitioners/Call Group **Does Not Apply ☐**

A. Provider Name & Degree: _____ **Specialty:** _____

Provider Address: _____ _____ **State:** ____ **ZIP:** _____

Provider Phone#: _____

B. Provider Name & Degree: _____ **Specialty:** _____

Provider Address:_____ _____ **State:** ____ **ZIP:** _____

Provider Phone#: _____

C. Provider Name & Degree: _____ **Specialty:** _____

Provider Address:_____ _____ **State:** ____ **ZIP:** _____

Provider Phone#: _____

Please duplicate this sheet if there are additional Admitting and Covering providers to list

PROSPECTIVE PROVIDER

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PRACTICE LOCATION(S) PAGE 2 of 2
PLEASE DUPLICATE THESE SHEETS FOR ADDITIONAL OFFICE LOCATIONS AS NEEDED.

Type of Location (check all that apply):

☐ Ambulatory Surgical Center (ASC) ☐ Birthing Center ☐ Federally Qualified Health Center (FQHC) ☐ Home ☐ Hospice ☐ Hospital

☐ Public Health ☐ Rural Health Clinic (RHC) ☐ School Based Health Center (SBHC) ☐ Skilled Nursing Facility (SNF) ☐ Urgent Care

☐ Chemical Dependency (CD) ☐ Mental Health (MH)
Is this location certified by the OHA Addiction and Mental Health Division? ☐ YES ☐ NO

☐ Other. Please explain: _____

Are Primary Care Services offered at this location? ☐ YES† ☐ NO

PCPs: Should new members be assigned to the clinic or the physicians? ☐ Clinic ☐ Physician

PCPCH Tier: ☐ N/A ☐ 1. ☐ 2. ☐ 3. FQHC? ☐ YES ☐ NO Tribal Health? ☐ YES ☐ NO RHC? ☐ YES ☐ NO

Medicare Capacity: _____ Medicaid Capacity: _____

Gender Limitations: _____ Age Limitations: _____ Other Limitations: _____

Does this Practice Location provide any of the following? (check if applicable):

Educational Certification or Accrediting Program ☐	Age Appropriate Immunizations ☐	Allergy Injections ☐	Allergy Skin Testing ☐
In-Office Anesthesia ☐ What Classes or Categories of Anesthesia?		Anesthesia Administered By (last, first):	
Asthma Treatment ☐	Cardiac Stress Test ☐	Care of Minor Lacerations ☐	EKG Services ☐
Flexible Sigmoidoscopy ☐	IV Hydration Treatment ☐	Laboratory Services ☐ CLIA Certification Level	
Office Gynecology ☐	Osteopathic Manipulation Therapy (OMT) ☐	Phlebotomy ☐	Physical Therapy ☐
Pulmonary Function Testing ☐	Tympanometry/Audiometry Screening ☐	Radiology Services ☐ X-Ray Certification Type	
Non-English Language Spoken by Office Personnel ☐	Languages	Employee Type	Employee Name (last, first):
Interpreter Services ☐	Languages		
Other Services (list) ☐			

Please indicate if this Practice Location has the following:

A. **Street level access or a wheelchair accessible ramp into the facility ☐ YES ☐ NO**
B. **Wheelchair accessible lavatory ☐ YES ☐ NO**
C. **Wheelchair access to examination rooms ☐ YES ☐ NO**
D. **Doors with levered hardware or other special adaptations for wheelchair access ☐ YES ☐ NO**

*** If your group is pursuing a Medicaid Contract and the Organizational NPI(s) and/or Physician NPI(s) are not enrolled in Oregon Medicaid, additional information will be required for enrollment.**
*** If your group is pursuing a Medicare Contract and the Organizational NPI(s) and/or Physician NPI(s) are not enrolled in Medicare, you will need to contact CMS to start the enrollment process.**
†FamilyCare requires that Naturopathic Doctors (ND) have oversight by an MD or DO in order to provide Primary Care services. While FamilyCare members may bill for services, FamilyCare does not assign members to NDs as a member's PCP.

PROSPECTIVE PROVIDER

REQUEST FORM

FamilyCare Health

MENTAL HEALTH AND CHEMICAL DEPENDENCY PROVIDERS – LEVEL OF CARE

PLEASE DUPLICATE THESE SHEETS FOR ADDITIONAL OFFICE LOCATIONS AS NEEDED. REFERENCE THE SITE WHICH THE INFORMATION APPLIES TO.

- ☐ A&D Residential
- ☐ Acute Inpatient Hospital Psychiatric Care
- ☐ Community Based Crisis Stabilization Services (CBCSS)
- ☐ Community Mental Health Program (CMHP)
- ☐ Detoxification Facility
- ☐ Early Intervention (EI)
- ☐ Electroconvulsive Treatment (ECT)
- ☐ Intensive Outpatient (IOP)
- ☐ Intensive Treatment Services (ITS) – Community Based
- ☐ Mobile Crisis Unit
- ☐ Outpatient Chemical Dependency – Office Based
- ☐ Outpatient Mental Health – Office Based
- ☐ Peer Services
- ☐ Psychiatric Day Treatment Services (PDTS)
- ☐ Respite, Adult – Home ☐ Facility ☐
- ☐ Respite, Children's – Home ☐ Facility ☐
- ☐ Walk-In Clinic

MENTAL HEALTH AND CHEMICAL DEPENDENCY PROVIDERS – PROVIDER FOCUS

PLEASE DUPLICATE THESE SHEETS FOR ADDITIONAL PROVIDERS AS NEEDED. REFERENCE THE PROVIDER WHICH THE INFORMATION APPLIES TO.

Please select up to eight (8) areas of focus

- ☐ Acceptance and Commitment Therapy
- ☐ Addictions Psychiatry
- ☐ Addictions Specialist
- ☐ Adolescent Psychiatry (13yo-18yo)
- ☐ Adult Psychiatry (18yo-65yo)
- ☐ Anger Management
- ☐ Anxiety Disorders
- ☐ Applied Behavioral Analysis
- ☐ Attention Deficit and Hyperactivity
- ☐ Autism Spectrum Disorder
- ☐ Biofeedback
- ☐ Chemical Dependency
- ☐ Child Abuse & Neglect
- ☐ Child Psychiatry (6yo-12yo)
- ☐ Christian Counseling
- ☐ Chronic or Terminal Illness
- ☐ Codependency Behavioral Therapy
- ☐ Cognitive Behavioral Therapy
- ☐ Cognitive Disorder / Intellectual Disabilities
- ☐ Comorbidity
- ☐ Couples Counseling
- ☐ Crisis Intervention
- ☐ Depression
- ☐ Detoxification
- ☐ Developmental Disorders
- ☐ Dialectic Behavioral Therapy
- ☐ Dissociative Disorder
- ☐ Domestic Violence
- ☐ Early Childhood Psychiatry (0yo-6yo)
- ☐ Eating Disorders
- ☐ Electroconvulsive Therapy
- ☐ EMDR
- ☐ Ethnic/Multicultural Issues
- ☐ Family Therapy
- ☐ Gay-Lesbian Issues
- ☐ Gender Identity
- ☐ Geriatric / Aging Counseling
- ☐ Geriatric Psychiatry (65yo+)
- ☐ Grief and Bereavement
- ☐ Group Therapy
- ☐ Health Psychology & Counseling
- ☐ Hearing Impaired
- ☐ HIV/AIDS
- ☐ Hypnotherapy
- ☐ Life Management Counseling
- ☐ Managed Disability
- ☐ Marriage and Family Therapy
- ☐ Men's Issues
- ☐ Mood Disorders
- ☐ Multicultural Integration
- ☐ Neuropsychological Testing
- ☐ Obsessive-Compulsive Disorder
- ☐ Occupational Issues
- ☐ Organic Disorders
- ☐ Pain Management
- ☐ Parenting Issues
- ☐ Personality Disorders
- ☐ Pharmacology-Medication Management
- ☐ Post-Traumatic Stress Disorder
- ☐ Psychological Testing
- ☐ Psychotic or Schizophrenia Disorders
- ☐ Reproductive Health & Maternity
- ☐ Sex Offender Treatment
- ☐ Sexual-Physical Abuse
- ☐ Sexual Dysfunction
- ☐ Stress Management
- ☐ Life Management Counseling
- ☐ Transition Aged Youth (16yo-25yo)
- ☐ Women's Issues
- ☐ Other:_____

***** Behavioral Health practitioners must also submit résumés and/or CVs *****

FamilyCare Health Plans Network Development

825 NE Multnomah St., Suite 1400, Portland, OR 97232 ▪ Ph: 503-222-3205

PROSPECTIVE PROVIDER

REQUEST FORM

FamilyCare Health

PRACTITIONER INFORMATION

LIST ALL PRACTITIONERS ASSOCIATED WITH THIS TAX ID NUMBER WHO WILL BE COVERED BY THE CONTRACT AND WHO WILL BE SEEING FAMILYCARE MEMBERS.

Please note that, in most cases, <u>all</u> practitioners will be required to submit a completed and current Oregon Practitioner Credentialing Application (OPCA) before joining the FamilyCare panel and receiving contracted rates. FamilyCare cannot pay contracted rates until a provider is credentialed and the contract is fully executed.

PRACTITIONERS TO BE COVERED UNDER THE CONTRACT AND SEEING FAMILYCARE MEMBERS

A. Practitioner Name & Licensures*:_____
Practice Specialty*: _____ **Individual NPI*:**_____
Primary Care Physician*: ☐ YES ☐ NO If YES, PCP Capacity*:_____
Oregon Medicaid ID# (Required for Medicaid Contract):_____
Medicare ID# (Required for Medicare Contract):_____ _____
Languages Spoken:_____ **Race:** **Ethnicity:**
Do you work or volunteer for any other entities? ☐ Yes ☐ No.
Name of entity: _____**Role:** _____

B. Practitioner Name & Licensures*:_____
Practice Specialty*: _____ **Individual NPI*:**_____
Primary Care Physician*: ☐ YES ☐ NO If YES, PCP Capacity*:_____
Oregon Medicaid ID# (Required for Medicaid Contract):_____
Medicare ID# (Required for Medicare Contract):_____ _____
Languages Spoken:_____ **Race:** **Ethnicity:**
Do you work or volunteer for any other entities? ☐ Yes ☐ No.
Name of entity: _____**Role:** _____

C. Practitioner Name & Licensures*:_____
Practice Specialty*: _____ **Individual NPI*:**_____
Primary Care Physician*: ☐ YES ☐ NO If YES, PCP Capacity*:_____
Oregon Medicaid ID# (Required for Medicaid Contract):_____
Medicare ID# (Required for Medicare Contract):_____ _____
Languages Spoken:_____ **Race:** **Ethnicity:**
Do you work or volunteer for any other entities? ☐ Yes ☐ No.
Name of entity: _____**Role:** _____

D. Practitioner Name & Licensures*:_____
Practice Specialty*: _____ **Individual NPI*:**_____
Primary Care Physician*: ☐ YES ☐ NO If YES, PCP Capacity*:_____
Oregon Medicaid ID# (Required for Medicaid Contract):_____
Medicare ID# (Required for Medicare Contract):_____ _____
Languages Spoken:_____ **Race:** **Ethnicity:**
Do you work or volunteer for any other entities? ☐ Yes ☐ No.
Name of entity: _____**Role:** _____

***Required Field**

Please duplicate this sheet if there are additional Practitioners to list. Please reference this section.

FamilyCare Health Plans Network Development
825 NE Multnomah St., Suite 1400, Portland, OR 97232 ▪ Ph: 503-222-3205