Provider Specialty Profile

This profile was created to capture specific information that will allow us to improve our referral process by closely matching member needs with provider services. Please note that incomplete information will be rejected.

Provider Information

Name: _____ _____ _____
First Middle Last Suffix

Licensure: _____ State of Licensure: _____ License Number: _____
(MD, ARNP, PhD, LCSW , etc.)

DOB: _____ Provider e-mail: _____

Member ID #: _____

Individual NPI #: _____ Individual Taxonomy Type: _____

Group NPI #: _____ Group Taxonomy Type: _____

Are you Board Certified? ☒ Yes ☒ No
If "Yes," what type of Board Certification do you have? _____

Do you have admitting privileges/ affiliations at a hospital? ☒ Yes ☒ No
If "Yes," please list the hospital(s) where you have privileges: _____

Credentialing Information

Credentialing Contact Name : _____ Phone: _____

Email: _____ Fax: _____

Council for Affordable Quality Healthcare (CAQH) Participant? ☒ Yes ☒ No If yes, list CAQH# * _____

*Please be sure all information, attachments and attestations are up to date and access has been granted for Cenpatico to view your data
*If you do not have a CAQH number, you can obtain one by going to proview.caqh.org
*Cenpatico only accepts credentialing submissions through CAQH. For more information, visit www.caqh.org

Practice Information

Group Name/Clinic Name: _____ Tax ID# _____

Primary Office Street Address: _____

City: _____ State: _____ Zip: _____ County: _____

Phone: _____ Secure Fax: _____

Please ensure this address and all additional practice locations are entered on your application.

Billing Office Contact Information: _____
Name Phone Email address

Billing Address: _____
City State Zip

Mailing Address: _____
City State Zip

Provider Specialty Profile

Office Hours	
MONDAY	
TUESDAY	
WEDNESDAY	
THURSDAY	
FRIDAY	
SATURDAY	
SUNDAY	

Are you currently accepting new members? ☐ Yes ☐ No

Appointment Availability: Please indicate your availability for the following appointment types:

* **Routine** appointment – within 10 business days (14 calendar days) ☐ **Yes** ☐ **No**

* **Urgent** appointment – within 24 hours ☐ **Yes** ☐ **No**

* **7-day Post Hospital Discharge** appointment ☐ **Yes** ☐ **No** *Please indicate location:* ☐ *In home* ☐ *In office*

Ethnicity: Please choose the option that best describes your ethnic background (used to meet member referral requests)

☐ American Indian or Alaskan Native ☐ Asian or Pacific Islander

☐ African America, Black ☐ Hispanic or Latino

☐ White, Non-Hispanic ☐ other: _____(please specify)

Do you provide services in languages other than English? ☐ Yes ☐ No

If "Yes," what other languages? _____

Does your office staff speak languages other than English? ☐ Yes ☐ No

If "Yes," what other languages? _____

Do you offer emergency services? ☐ Yes ☐ No

If "Yes," please describe: _____

Are the following areas in your office handicapped accessible? (Check those that apply)

☐ Building ☐ Restroom ☐ Therapy Room ☐ Parking

What are your age restrictions? Youngest Age: _____ Oldest Age: _____

Do you provide services to both males and females? ☐ Yes ☐ No

If "No," please explain: _____

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Treatment Expertise/Specialties

Please select the types of services you offer, including the disorders you treat and the modalities you practice. (Check those that apply)

NOTE: Please submit evidence of certificates or transcripts that account for the associated trainings in the treatment modalities and/or disorders selected below.

Certifications			
	Art Therapy		Positive Behavior Support
	Center of Excellence		SBIRT
	Emergency Services Provider		Trauma Informed Care
	Lead Behavior Analysis Therapist		
Settings/Populations Treated			
	Adolescents		Homelessness
	Adults		Men
	Blind/Visually Impaired		Mobile Crisis
	Children		Nursing Home
	Community Based		Physical Disability
	Deaf/Hearing Impaired		Serious Emotional Disturbance
	Developmental Disability		Serious Mental Illness
	Emotionally Disturbed		Severe Persistent Mentally Ill
	Gay/Lesbian		School Based
	Geriatric		Telemedicine
	Hospital Based		Women
	Home Based		Young Children

Treatment Modalities/ Approaches			
	Applied Behavioral Analysis (ABA)		Hypnosis
	Addictive Disorders		Intensive Family Intervention
	Adolescent Psychotherapy		Individual Therapy
	Adolescent Sex Offender		Intensive Outpatient
	Adolescent Psychiatry		Intake Assessment
	Adoption Issues		Medication Management
	Alcohol/SA Treatment		Methodone/Suboxone
	Anger Management		Mood Disorders
	Art Therapy		Neuropsychological Testing
	Attachment Therapy		Neuro-Linguistic Programming (NLP)
	Behavioral Therapy		Outcomes Oriented Therapy
	Brief Therapy		Parent Child Interaction Therapy (PCIT)
	Biofeedback		Play Therapy
	Chemical Dependency Assessment		Psychological Testing
	Child Parent Psychotherapy (CCP)		Psychoanalytic Therapy
	Child Psychological Testing		Psychodynamic Therapy
	Christian Counseling		Psychopharmacology
	Client Centered Therapy		Pain Management
	Cognitive Therapy		Rationale Emotive Therapy
	Couples Therapy		Relapse Prevention
	Crisis Intervention/Stabilization		Relationship Disorders

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	Critical Incident Debriefing		Sensory Processing/Integration
	Cognitive Rehab Therapy		Sexual Compulsions/Addictions
	Child Psychiatry		Sex Therapy
	Dialectical Behavioral Therapy		Solution Empowerment Therapy
	Developmental Evaluation		Stress Management
	Domestic Violence		Tobacco
	ECT		Trauma Focused- CBT
	EMDR		Trauma Focused Cognitive Behavioral Therapy (TF-CBT)
	Evaluation/Assessment		Trauma Informed Care (TIC)
	Family Therapy		Trust Based Relational Intervention (TBRI)
	Family Systems		Weight Management
	Gay/Lesbian/Bisexual		Tobacco Cessation
	Group Therapy		
	Geriatric Psychiatry		
	Gestalt		

Disorders/Issues			
	Addictive Medicine		Impulse disorders
	ADD/ADHD		Infertility
	Addictive Disorders		Inpatient Attending
	Adjustment Disorder		Inpatient Consult MD
	Adolescent Behavior Disorders		Learning Disability
	Adoption Issues		Medical Evaluation
	Adult ADD		Medical Illness/Chronic Illness
	AIDS/HIV		Men Issues
	Anger Management		Mood Disorders
	Anxiety/Panic Disorder		Marital Issues
	Attachment Disorder		Mental Retardation
	Autism/Aspergers		Obsessive Compulsive Disorder
	Bipolar Disorders		Oppositional Defiant Disorder
	Chemical Dependency		Organic Mental Disorder
	Christian/Spiritual		Parenting Issues
	Chronic Pain/Pain Management		Personality Disorders
	Crisis Stabilization		Post-Partum Disorder
	Cultural Issues		PTSD
	Child/Parent Bonding		Panic Disorder
	Co-occuring Disorders		Phobias
	Cognitive Disorder		Physical Abuse
	Concussion		Reactive Attachment Disorder
	Criminal Offenders		Relapse Prevention
	Dementia Disorders		Sexual/Physical Abuse (Adults)
	Developmental Disorder		Sexual/Physical Abuse (Children)
	Disruptive Behavior		Schizophrenia
	Dissociative Disorder		Serious/Persistent Mental Illness
	Separation/Divorce		Sexual Disorders
	Domestic Violence		Sexual Dysfunction
	Dual Diagnosis		Sexual Abuse/Incest
	Depression		Sleep Disorder

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	Disabled		Step/Blended Families
	Eating Disorders		Stress Management
	Equine Assisted Therapies		Self Injury
	Family Dysfunction		Sexual Offender
	Feeding Disorders		Substance Abuse
	Gay/Lesbian/Bisexual		Suicide
	Gender Identity Issues		Tobacco Cessation
	Grief/Loss/Bereavement		Women Issues
	Head Trauma		Work Related Problems
	Home Visits		

Signature: _____ **Date:** _____